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Chemist&Druggist
The Newsweekly for Pharmacy

11 September 2004

Second bogus drugs case sparks inquiry

Cornish PCT rolls out multi-PGD scheme

Pfizer combats threats to US with UK quota

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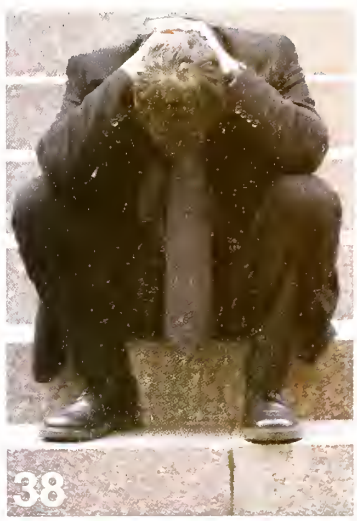
News

Regulars

Practice



Features

NATIONAL

Fake Reductil in drug supply chain

Another counterfeit product has emerged onto the UK medicines market. Last week the MHRA issued its second recall in a fortnight, this time for a product supplied as the anti-obesity drug Reductil.

The first recall in 10 years for a fake drug was put out at the end of August after a counterfeit version of Cialis was found after being dispensed from a pharmacy in Cheshire (*C&D, August 28, p5*).

The MHRA said that so far 29 suspect packs have been returned. It explained: "Counterfeit Reductil 15mg has been attempted to be sold into the legitimate UK supply chain. A UK wholesaler was offered the product by way of three sample packets from a European supplier. The UK wholesaler immediately informed the MHRA of their suspicions when the packet was received and observed."

The medicines watchdog is unable to name any of the parties involved to avoid prejudicing its investigation but is able to confirm that the false Reductil has reached more than one retail outlet. Abbott Laboratories, manufacturer of Reductil, is helping in the recall.

Initial results of analysis performed by the MHRA on the counterfeit material do not indicate that it poses an immediate risk to patients.

The fake blister packs of 28 capsules supplied in two strips of 14 of Reductil 15mg are a very close match in appearance to the authentic product but may be distinguished by the batch number 65542 and carry an expiry date of 10/2007. It is not known if other batch numbers are involved. Authentic products bear a numeric batch number with a one letter alphabetic suffix (eg 141998D).

The MHRA is already investigating how fake Cialis got into the legitimate supply chain. It added: "There is no evidence to suggest that parallel imports provide any more of an opportunity to introduce fake drugs into the country over non-parallel imported products. In both cases parallel imports do not appear to be involved."

Pharmaceutical manufacturers' body the ABPI concluded: "The incidents involving Reductil and Cialis emphasise how important integrity of supply is and the risks involved in obtaining supplies from sources other than the original manufacturers."

The RPSGB has issued advice for pharmacists on how to deal with the recalls of these counterfeit medicines.

For more information:

www.mhra.gov.uk

www.rpsgb.org

CORNWALL

Cornwall's pharmacists allowed to treat infections

A scheme allowing pharmacists to supply Prescription Only Medicines for common infections is to be rolled out to all pharmacies in central Cornwall early next year.

Under the project, pharmacists can supply trimethoprim for uncomplicated urinary tract infections in women, fusidic acid or chloramphenicol eye drops for bacterial conjunctivitis, fusidic acid cream for impetigo, and nystatin with hydrocortisone cream for nappy rash via patient group directions.

Around 40 pharmacists in 19 pharmacies currently participate in the Central Cornwall PCT scheme and 168 products were [illegible] between April and August. Prescribing support pharmacist Jackie Palmer said the introduction of the new GMS contract and the accompanying change in out-of-hours service provision meant that the remaining 11 pharmacies in the PCT were likely to join the scheme in early 2005.

Participating pharmacies receive a £5 consultation fee per patient, a £10 monthly administration fee and medicine costs. The service is free to patients exempt from prescription charges but other patients are required to pay £6.40 if a product is supplied.

Ms Palmer said the PCT was looking to extend the scheme to include emergency hormonal contraception for teenagers and nystatin suspension for oral thrush. "Patient feedback has been very good. The one negative thing has been the lack of private consultation areas but that is being addressed by many pharmacies," she commented.

Graham Brack, Cornwall and Scilly Isles LPC treasurer and proprietor of Reeds Pharmacy in Truro, has been participating in the scheme for four weeks. He commented: "Lack of a consultation room is not a problem. The paperwork means patients can point to responses if they don't want to say it out loud so it is very discreet."

MEDICINES

All about medicines management

A resource detailing the ideal medicines management programme has been published by the Department of Health.

In such a programme, patients would know when and how to take their medicine, why it was prescribed, what to do about side effects and what non-pharmacological approaches or self-help measures there might be.

Patients would also have access to high quality, evidence-based information about their condition and its treatment. While at PCT level, processes should maximise community pharmacists' contribution to patient care.

The document, *Management of Medicines*, is intended to support implementation of the medicines management aspects of the national service frameworks for diabetes, renal services and long-term conditions.

For more information:

www.doh.gov.uk

MEDICINES

Buy herbal remedies at pharmacies

Patients should buy herbal medicines from health practitioners such as pharmacists to prevent harming their health with dangerous interactions, an academic pharmacist has warned.

A high proportion of the population is at risk of interactions between herbal and conventional medicines because they take herbal remedies without first checking with a healthcare professional, said Peter Houghton pharmacognosy professor from King's College London, at the BA Festival of Science in Exeter.

"Although your risk of dying from taking a herbal remedy is extremely small, some interact with other medicines with serious consequences," Professor Houghton said.

The MHRA has issued advice to consumers and those in the herbal sector on the "poor quality of some traditional Chinese medicines available in the UK.

For more information:

www.mhra.gov.uk

ENGLAND

Pharmacy plays host to DoH personnel in Yorkshire

by Asha Fowells
afowells@cmpinformation.com

Senior Department of Health personnel made nearly 50 visits to health service providers, including a pharmacy, in West Yorkshire last week.

As part of the exercise, public health minister Melanie Johnson called into Cohen's Pharmacy in the Moortown area of Leeds (*pictured above*).

Health secretary John Reid, chief medical officer Sir Liam Donaldson and NHS head Sir Nigel Crisp were among those calling on clinics, hospitals and GP practices in and around Leeds, Bradford and Wakefield last Thursday.

At the pharmacy, Ms Johnson saw a minor ailments project being piloted by Leeds North East PCT.

Medicines management facilitator Kim Taylor said the scheme was being refined and would be rolled out to all 23 pharmacies in the PCT in the near future.

In addition, Pfizer, with whom a sponsorship deal has recently been agreed, will be assisting with publicity for the project, Ms Taylor added.

Pharmacy manager Conal Farrey said: "We told [Ms Johnson] we want to extend the scheme to include some PGDs especially for EHC because a lot of the GPs are closing on Saturdays.

"She was very receptive and seemed very interested in what we had to say. She said her mum is a pharmacist so she empathised with what we were saying."

WALES

New card for Welsh script charges

PSNC has published a prescription card to reflect the lower prescription charges payable in Wales from October 1.

Welsh prescription item charges will fall from £6 to £5 next month and pre-payment prices will fall from £31.40 to £26.16 for a four-month certificate and from £86.20 to £71.83 for a 12-month certificate. Patients aged less than 25 years will continue to be exempt from prescription charges.

For more information:
www.psnc.org.uk

CPP sets out to tackle public health

The College of Pharmacy Practice is to set up a faculty for pharmacists with an interest in public health.

As a first step, the CPP will establish a public health interest group, which will provide a framework of practice standards to help pharmacists develop their general or specialist public health role.

These roles could include: medicines management, maximising health gain from resources, mapping and monitoring medicines use patterns, smoking cessation, EHC, pharmaceutical waste disposal, and disease screening.

All pharmacists are eligible to join and do not need to be CPP members.

For more information:
Tel: 024 7622 1359
E-mail: *info@collpharm.org.uk*

$3m funding for pregnancy trial

US researchers have received almost $3 million to fund the first study into medications in pregnant women.

Mary Hebert, associate professor of pharmacy at Washington University, leads the team that will look into why pregnant women metabolise drugs differently and how they affect mother and foetus.

"The work done by the research units will be able to address the question of how to choose the best drug and the best dosage for a pregnant woman," said Dr Hebert.

LPC website

Lambeth, Southwark & Lewisham LPC has launched a database on its website to help the public locate pharmacies by postcode, opening time, location, language spoken and range of services provided.

For more information:
www.lsllpc.com

SOP use impacts on locum status

by Asha Fowells
afowells@cmpinformation.com

Locum pharmacists who, as part of their locum agreement, sign to work within a pharmacy's standard operating procedures, will be classified as employees, the NPA has said.

The NPA's tax consultants have said such an agreement would breach the locum's self-employed status, NPA pharmacy practice director Colette McCreedy has warned. But she added: "A pharmacy owner may draw the locum's attention to the pharmacy's SOPs and ask verbally that he or she works within them, providing of course that the locum is happy, professionally, with the SOP. If a locum pharmacist chose to work against his or her own SOP rather than the proprietor's and an error arose, we would still provide that locum with indemnity cover."

The Inland Revenue said it could not comment on whether locum pharmacists should follow a pharmacy's SOPs, as it was a matter of individual choice, but said: "There is no statutory definition of employment and self-employment for tax and NICs purposes. It is the terms upon which the locum is engaged (written, oral or implied) that determine status, not the duties performed by the regular pharmacist."

Undertaking the full range of duties of an employed pharmacist, such as cashing-up and general staff supervision, would mean the locum pharmacist was more likely to be an employee, it added.

The Company Chemists' Association said that, although employers could not require locums to follow their SOPs, it was important to recognise that locums were free to do so, as part of the service they provide. This should satisfy everyone including the Inland Revenue because the locum would be choosing, it added.

CCA chief executive Colin Baldwin said: "All pharmacists – whatever their employment status – are required to comply with legislation and policies devised for the benefit of the public. SOPs have been introduced by our professional and regulatory body to provide a framework for best professional practice. It seems inappropriate that personal tax issues, employment status and professional accountability should be linked in this way."

Pharmacists' Defence Association director Mark Koziol agreed that pharmacists who use their professional judgement to decide whether to follow a pharmacy's SOPs would not be in breach of their self-employed status. "The *Code of Ethics* requires the individual to decide whether the SOP is effective, safe and reasonable," he added.

Doubt over NHS value for money

Whether increased NHS funding is producing value for money in terms of cost reductions or health gain is "unanswered and unanswerable", the RPSGB's latest quarterly *Health Policy Review* has concluded.

There are improvements such as reductions in waiting lists for treatments and outpatient appointments, shorter waits for GP appointments, and increases in prescriptions, but the "coverage is patchy because data is missing or incomplete", the report says.

Highlighting the requirement in the *NSF for Older People* for patients over 75 to have regular medication reviews, the report says that no data for this age group is available but, for the over 65s, "it appears that only half receive an annual review".

For more information:
www.rpsgb.org.uk

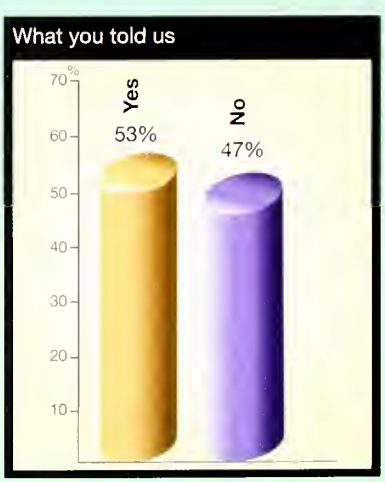
Questiontime

Last week we asked you: "Will your pharmacy be ready for the Disability Discrimination Act, which comes into force on October 1?" You replied (see right):

This week's question: "In light of the two recalls for counterfeit medicines, do you think the problem with fake medicines is over?"

- Yes – for the foreseeable future
- No – expect the occasional problem
- No – expect significantly more

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on September 14 to cast your vote. We will publish the results in *C&D*, September 18.



ComingEvents

SEPTEMBER 14
Oxfordshire Branch RPSGB
Treatment and Management of Schizophrenia, by Michael Marven, chief pharmacist, Littlemore Hospital.
Yarnton Manor, Oxford Centre for Hebrew & Jewish Studies.

Introducing our £1million makeover.

Say hi to Senokot Hi-Fibre and farewell to Fybogel.

- Fybogel has been re-branded as Senokot Hi-Fibre.

Extra sales appeal from the UK's No1 selling constipation brand.*

- £1m national TV campaign dedicated to Senokot Hi-Fibre.
- To maximise your sales potential, stock up now – TV campaign breaks October 2004.

all outlets 52 w/e 10th July 2004.

ys read the label.
kot and ⓘ are trademarks.

New From Senokot

INDUSTRY

Pfizer's UK supply quota proposal causes concern

Pfizer is introducing a quota system for its products in the UK in an attempt to counter imports of potentially unsafe medicines into the USA.

Pfizer has warned UK wholesalers that it intends to cap supplies here, allowing only sufficient for the UK's needs. It says that patient safety is at risk of being compromised in Europe in the cross-border supply chain with the implication that these products could then be imported into the USA.

However, media reports this week suggested the move was motivated more by the threat of cheaper imports into the USA. The *Financial Times* said: "Pfizer has warned UK wholesale customers that it will monitor supply requests and only sell enough prescription drugs to satisfy domestic demand, in a move similar to its efforts to combat Canadian sales to the USA."

Several pharmaceutical companies already place quotas on the Canadian market, where prices can be substantially cheaper, to limit the amount of importation into the USA.

The British Association of Pharmaceutical Wholesalers confirmed this week that it had been contacted by Pfizer. "We are very concerned about Pfizer's proposal to cap supplies," said Steven Dunn, BAPW chairman and group managing director of AAH Pharmaceuticals.

"Pfizer has written to all BAPW members advising them that they intend quota-ing supply by depot, but gave us no indication as to how quotas will be established. Demand for different drugs is volatile and we are concerned that patients won't be able to get the medicines they need when they need them. I have written to Pfizer in my capacity as chairman of BAPW and am awaiting a reply."

On Tuesday, Pfizer said: "The primary objective of Pfizer's supply policy in Europe is to ensure the availability of sufficient supplies of Pfizer products to meet the needs of pharmacies and patients in each country in which we operate.

"In Europe, patient safety is at risk of being compromised by medicines being interfered with outside the manufacturer's control, in the cross border supply chain. Recent examples have included counterfeit medicines, deficient repackaging, wrong package contents and incorrect relabelling.

"Pfizer is also concerned about possible supply shortages in the UK and has reminded wholesalers of the company's commitment to ensuring an adequate supply of genuine Pfizer medicines to UK patients. The primary objective of Pfizer's supply policy in Europe is to ensure the availability of sufficient supplies of Pfizer products to meet the needs of pharmacies and patients in each country in which we operate."

Pfizer is also currently doing battle with websites offering 'generic' Lipitor. Patent protected Lipitor is an anti-cholesterol product. However, tablets from two of the web suppliers have been tested and found to have no cholesterol-lowering effect. Last month Pfizer took action against sites selling illegal versions of its erectile dysfunction drug, Viagra (sildenafil).

Alliance UniChem buoyant

The Government's announcement on the control of entry regulations seems to have pleased the City. Share prices in pharmaceutical wholesaler Alliance UniChem saw the second highest rise in the stock market on August 31 and peaked at 679.5p on September 2. At the beginning of June ordinary shares were 631p.

LEGAL

GSK under fire again

GlaxoSmithKline could face an estimated £200 million bill for damages in the USA if a lawsuit being attempted by Meshbesher & Spence is successful. The Minnesota-based solicitors are recruiting parents of adolescents given its antidepressant Seroxat (paroxetine) to join its class action. £200m is thought to represent the money spent on the drug for children and teenagers.

While denying it suppressed evidence that the drug could make under-18s suicidal, last month GSK agreed to pay $2.5m to avoid the costs of litigation initiated by New York state attorney Eliot Spitzer. It has also agreed to publish Seroxat clinical trials results on its website.

Cancer Research UK has praised GSK for its general policy decision in June to similarly publish trials results of all its marketed products. This process, expected to be completed by the end of next year, was begun two weeks ago with trials data for its diabetes treatment Wandia.

In a *Financial Times* interview, Dr Richard Sullivan, head of clinical programmes at Cancer Research UK, urged all companies to follow in the footsteps of Eli Lilly and GSK.

INDUSTRY

Illegal blood strip imports found on pharmacy shelves

Illegally imported Roche Diagnostics blood glucose strips have been found on pharmacy shelves in the UK, says the company.

Roche says it has stopped four illegal imports in the UK of the blood glucose strips since August last year and is now looking for safeguards for the future.

The imported strips for BM-Test 1-44, BM-Accutest and Accu-Chek Advantage infringed Roche's trademarks as they were first marketed outside the EEA, then parallel imported into the EEA for sale. Taiwan was one of the main countries where the blood strips were imported from, says the company.

"Illegal activity does not only affect the company. It is also unfair to the vast majority of wholesalers who deal only in legitimate products and face unfair competition from illegal importers," said national account manager Mark Weston.

DDA sees 'difficulties' in Shipman proposals

by Gary Paragpuri
gparagpuri@cmpinformation.com

The Dispensing Doctors' Association has highlighted "potential practical difficulties" posed by some of the recommendations in the Shipman Inquiry's report on monitoring Controlled Drugs.

The proposal to include a doctor's GMC number, a patient identification number and a brief explanation of a patient's conditions on CD prescriptions could in practice prove to be "time consuming and over-bureaucratic", DDA chairman Dr Malcolm Ward says. The recommendation for inspectors to reconcile patient drug record cards (PDRCs) with pharmacy CD registers and GP records could be a "time consuming process", he adds.

"Problems will occur if the PDRC is lost or damaged at the patient's home. Who would be accountable? Replacements would not provide a full audit trail," Dr Ward says.

In the report, Shipman Inquiry chairman Dame Janet Smith raised the question of whether there should be a policy shift towards encouraging community pharmacies in rural areas to reduce the need for doctor dispensing, but Dr Ward described some of the comments in the report as "largely subjective and not evidence based". He added: "Dr Shipman was a prescribing doctor and the crimes he perpetrated as detailed in the report had nothing whatsoever to do with dispensing practice."

But a Shipman Inquiry spokesman said the inquiry process was evidence based and that recommendations followed extensive consultation to which the DDA contributed.

Describing the issue as difficult, DDA chief executive Dr David Baker said there was no evidence to support the perception that dispensing doctors are not as safe as prescribing doctors. He highlighted the fact that Dame Janet's report made no recommendations to stop doctors from dispensing.

Wales's youth minister Jane [illegible] campaign highlighting the importance of organ donation by taking part in a 5km fun run in Cardiff last [illegible]. The event was organised by the Kidney Research Unit for Wales Foundation which has promoted the issue of organ donation since 1981

Those in coastal areas are at highest risk of stroke

Adults living on the Sussex, Devon and Norfolk coasts are the most at risk in the UK of suffering a heart attack or stroke over the next 10 years, according to a new research service.

The data-modelling software has been developed by market data analysts Taylor Nelson Sofres (TNS) and the University of Portsmouth and is designed to model the prevalence of heart disease across specific locations in the UK. Using PCT-specific data, the estimate is based on the analysis of risk factors such as the region's smoking, age and weight statistics, compared to those of the UK as a whole.

TNS's cardiovascular analysis shows that nationally 11 per cent of the adult population have CV disease and a further 9 per cent is at risk despite being currently undiagnosed.

This figure rises to 12 per cent in the areas identified by TNS as being at risk, thanks to a combination of age and adverse lifestyle risk factors.

A similar model for type 2 diabetes is also available.

Commenting, Alastair Buxton, head of NHS Services at PSNC, says: "Population mapping may be useful in certain circumstances. But if pharmacists want to look for service development opportunities, their local knowledge and PMR will supplement information of this type which is normally contained in the director of public health's report and the local delivery plan."

PRACTICE

Know your numbers 2004

The Blood Pressure Association is urging pharmacists to take part in this year's Blood Pressure Testing Week following the success of last year's campaign.

The event that runs from September 13–19 is part of the charity's 'Know Your Numbers' awareness campaign. Last year, 1,320 of the 2,029 'pressure stations' were set up in pharmacies, and an estimated 148,000 people were tested. Nearly a fifth had not had been tested in the past five years, and nearly 40 per cent of those were found to be hypertensive.

For more information:
www.bpassoc.org.uk
Blood Pressure Association
Tel: 020 8772 4994

Deadline for Sabril case

Patients have until September 17 to join the group legal action against Aventis for vigabatrin side effects (*CD Mar 20, p6*).

The cut-off date for patients claiming they suffered irreversible visual field defects after taking the anti-epilepsy drug Sabril was extended from the original May deadline by the High Court earlier this year. A spokesman for solicitors' firm Wolferstans said it had 172 claimants who would receive financial support with legal fees from the Legal Services Commission.

AAH freebie

AAH Pharmaceuticals is supplying over 100 free copies of its *Guide to Continuous Professional Development* to randomly selected Vantage customers who do not currently have one.The manuals are part of AAH's commitment to community pharmacy, it said.

GREAT VALUE THRUSH TREATMENT, NO MESSING

Fluconazole 150mg single dose capsule provides symptomatic relief from the symptoms of thrush within 24 hours for most women[1]. At a RRP of £6.99 for one treatment, Care Fluconazole offers significant value for money to your customers, as well as a healthy profit on return for you.

For further information please call our friendly sales team on ***01484 848200*** *or contact your local sales representative.*

care

Quality medicines at careful prices

1. Nathan A. Non prescription medicines London: Pharmaceutical Press, 2nd edition 2002 p358-364

Prescriber Information

Name of the medicinal product: Fluconazole 150 mg Capsule

Therapeutic Indications: Treatment of vaginal candidiasis, acute or recurrent. Single dose treatment of partners with associated candidal balanitis.

Dosage: Adults (aged 16 to 60 years of age) One capsule.

Contra-indications: Known hypersensitivity to fluconazole, related azole compounds or any of the excipients. Co-administration with terfenadine or cisapride.

Special warnings and precautions for use: Adequate contraception necessary. A physician should be consulted if the patient or partner have had two infections of thrush in the last six months, is taking any medicine other than the Pill; has any disease or illness affecting the liver or kidneys or has had unexplained jaundice; suffers from any chronic disease or illness; is uncertain of the cause of the symptoms; had abnormal or irregular vaginal bleeding or a blood-stained discharge; has vulval or vaginal sores, ulcers or blisters; has lower abdominal pain or dysuria. In men, medical advice should be sought if sexual partner does not have thrush; they have penile sores, ulcers or blisters; there is abnormal penile discharge; penis has started to smell, dysuria. Patients should consult their doctor if symptoms have not been relieved within one week.

Interactions: Please refer to Summary of Product Characteristics.

Rarely rash, headache, hepatotoxicity and anaphylaxis.

Product Status: P

Marketing Authorisation Holder: Approved Prescription Services Ltd., Eastbourne BN22 9AG

Marketing Authorisation Number: 00289/0485

Trade Price: £3.39 (ex VAT).

Date of Preparation: June 2003.

Distributed by: Thornton & Ross Limited, Linthwaite, Huddersfield, West Yorkshire HD7 5QH. Tel. 01484 842217

For more information contact the Marketing Authorisation Holder.

Clear dosage instructions sought

The Royal Pharmaceutical Society's Council is taking action to ensure all prescriptions for medicines carry clear and complete dosage instructions.

The Society is pressing for this principle to be enshrined in legislation and built into the specifications for electronic prescribing. These matters are being discussed with doctors, nurses and other health professionals as part of the policy that pharmacists should have access to appropriate patient information. Similar moves are afoot to make sure patients' ages are included on prescriptions.

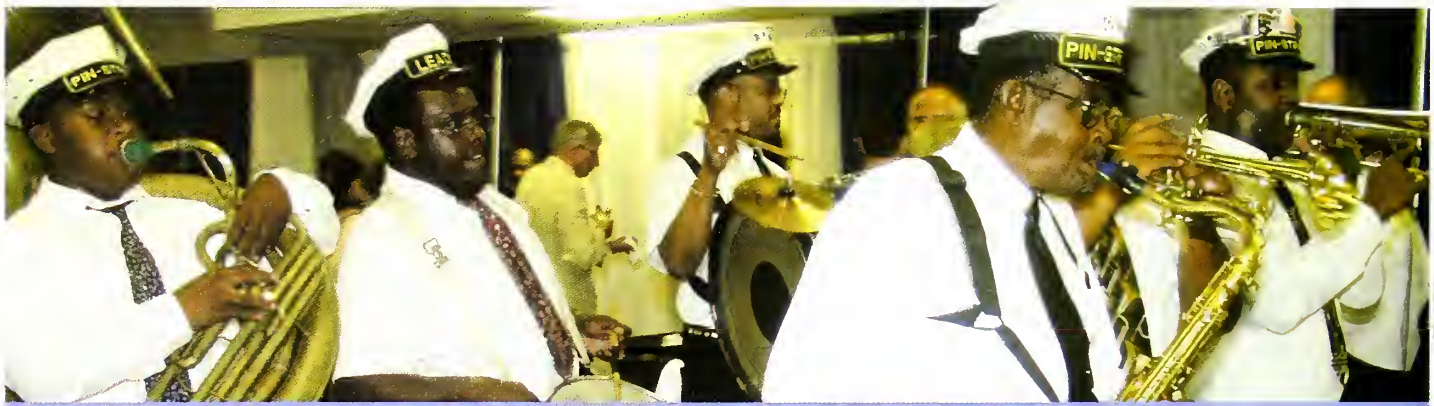
The Council made its commitment in its report on motions carried at the branch representatives' meeting in May.

In response to a motion asking Council to issue specific guidance to pharmacy owners to ensure staff took appropriate breaks when working long shifts, the Council replied that the *Code of Ethics* requires pharmacy owners not to impose conditions that might adversely affect pharmacists' ability to comply with their professional and legal duties. Pharmacists should only accept work for which they are fit, so it is up to them to consider their own expertise, the dispensing volume, number of trained staff and rest breaks when deciding whether or not to accept employment.

The *Working Time Directive 1998* entitles workers to at least a 20-minute break during a six-hour shift. Employers are responsible for making sure that workers *can* take their rest but not that they *do* so.

FIPConvention

Strength through unity



Pictures by Steven Kane

The 64th FIP Convention opened in traditional 'N'awlins' style last Sunday with gospel singing and a jazz band

Steve Kayne reports from the International Pharmaceutical Federation conference, FIP, which took place in New Orleans earlier this week

RPSGB director of corporate and strategic development Rob Darracott assured a large international audience that independent community pharmacy was alive and well and would thrive for many years to come. This was despite worries about it being unable to compete with the multiples.

Speaking in a debate entitled 'Are chain (multiple) pharmacies the bad guys?', Mr Darracott said there were benefits to accrue from independent contractors and small multiples linking together in 'virtual groups'. These can exhibit certain chain behaviour for members' mutual advantage while at the same time allowing continuing individual ownership. [illegible] buying was an obvious [illegible] but national branding [illegible] standardisation and [illegible] new services could also be [illegible]. The model had been [illegible] in several European countries, as well as in the USA. In the UK, wholesalers were particularly active in promoting such activity.

Rob Darracott:: benefits from linking together

Mr Darracott said the potential benefits of virtual group activity were often reduced by members' differing levels of compliance to protocols. This did not occur with the branches of large multiples who were subject to head office directives.

Dr Gill Hawksworth catches up on the FIP programme

Inger Lise Eriksen, president of the Norwegian Pharmaceutical Association, outlined the position in Norway following the complete deregulation of pharmacy after 400 years of professional control. She said the concept of virtual chain groups was helping her independent colleagues to survive as large international predators moved in on the market, buying up urban pharmacy premises in large numbers.

The traditional commercial argument in favour of multiples was put by Craig Fuller, president of the National Association of Drug Stores, Washington DC. Mr Fuller stressed that he saw the multiple and independent sectors as being complementary rather than in competition.

The speakers agreed that in the pharmacy retailing environment 'bigger was better'; many in the audience were not so sure.

In his address, the president Jean Parrot, of France, drew attention to the problem of counterfeit drugs that was posing a significant risk to public health in many developing countries. He also called on community pharmacists worldwide to allocate a minimum of one square metre of display space to the promotion of healthy living.

Oops...

Are your customers troubled by bladder weakness?

AVAILABLE NOW

The National Continence Check-up

Should your customers need to use bladder weakness protection there is a wide range of products available. TENA products are specifically developed to absorb urine, offering a high absorbency and therefore providing optimum security. The correct product will protect users most efficiently against bladder weakness and embarrassing odours, whilst allowing them total comfort. The choice of the most suitable product depends on your customer's particular degree of bladder weakness. The National Continence Check-up has been created to help your customers find the correct choice of TENA product.

For your FREE 'Oops...' Point of Sale material and in-store National Continence Check-ups, please call the Pharmacy Advice Line quoting C&D1109 on 0870 333 0874

The National Continence Check-up. Giving your customers the right solutions.

Supported by Dr. Chris Steele, GP and resident doctor on ITV's 'This Morning' programme

Incontact
www.incontact.org
registered charity number 1085095

The Continence Foundation
www.continence-foundation.org.uk
registered charity number 1014429

TENA
www.tena.co.uk

In association with these leading continence charities.

Statutory Committee encourages rehab rather than striking off

A Hertfordshire pharmacist, who blocked out a security camera lens while she stole prescription medicines to treat her depression and fuel her addiction to opiates, has had strict conditions placed on her practice.

"I was under the influence of drugs, I should not have been there because I was unemployable. I had no right to be there," Lesley Day told the RPSGB's Statutory Committee last month.

Ms Day faced a series of allegations of misconduct over a period between March 2001 and August 2003 for which she could have been struck off. But she pleaded to be allowed to stay in practice, even if it meant random tests for drugs and alcohol and a continuing programme of rehabilitation.

She said her last drink was on February 9 last year and she had not taken any medication for almost a year. She is currently working as a pharmacist.

The Committee decided that Ms Day should be allowed to continue practising but under strict conditions.

If she breached them she was in danger of being struck off the Register with immediate effect.

For the RPSGB, Geoffrey Hudson told the hearing that the first thefts occurred when Ms Day worked at Tesco's in-store pharmacy in Royston. Among the drugs she took were quantities of temazepam and Prozac.

Blocking out the camera took place at the Berkeley Pharmacy in Bedford, where she was also filmed eating food in the dispensary while preparing prescriptions and putting her feet up on the dispensing bench.

She had also been spotted apparently taking co-codamol and propranolol tablets while on duty.

During that time she made a major error by over-dispensing a drug to a patient in quantities that Mr Hudson said "could have been fatal".

The theft of the various drugs was discovered during a routine visit by Society inspectors. The police were called but there was no arrest or prosecution.

Ms Day said she had started drinking heavily in the mid-1990s and matters had gone from bad to worse in the lead up to her divorce in 1998.

She said she had rarely taken drugs or been drunk during working hours although she recalled taking two small bottles of pre-mixed gin and tonic into the Bedford shop to drink with her lunch.

Ms Day said she currently went to Alcoholics Anonymous meetings at least five days a week and believed her former addiction was now under control. She had a mentor as well as an addiction counsellor who she phoned regularly.

The counsellor, Joe Mee, said the Committee should be prepared to allow Ms Day to continue in practice under conditions. "My feeling is that there is an excellent prospect that she will do well. I think there is reason for the Committee to feel confident," he added.

Committee chairman Lord Fraser of Carmyllie QC said in normal circumstances the facts would have merited an immediate ban.

But they had been impressed by Ms Day's efforts to overcome her addiction problems and the evidence given by her counsellor that she was "on course for a lifetime recovery".

The conditions state that she should continue to see Mr Mee on a regular basis and to keep up her attendance at Alcoholics Anonymous.

She should also be willing to undertake random tests of no less than six a year, which should be reported back to the Society.

If the tests revealed that she had reverted to taking alcohol or drugs, the Committee would feel empowered to strike her off with immediate effect.

Reprimand for pharmacist found guilty of supplying Controlled Drugs to addicts

A Nottingham pharmacist twice convicted for supplying Controlled Drugs to addicts without proper prescriptions was reprimanded after admitting: "I'm stupid. I got too close to them."

Mohamed Kanani of Nottingham gave evidence to the Statutory Committee of the Royal Pharmaceutical Society last month where he faced various allegations of misconduct.

On January 20, 2003 he admitted breaches of the Misuse of Drugs Act 1971 and was fined a total of £2,500 plus costs of £[illegible] at Nottingham Magistrates [illegible].

[illegible] on April 28 this year at [illegible] Crown Court he again admitted illegally dispensing to addicts and was sentenced to a 12-months conditional discharge.

At the disciplinary hearing he described how his business, the Forest Pharmacy in Arnold Road, had got "out of control". He failed to recruit new staff and was running the shop single-handed.

An unannounced visit by a Society inspector revealed that on a number of occasions he had given addicts bulk supplies of methadone when they were only supposed to be given it on a daily basis.

In addition, he had failed to keep a proper record of Controlled Drugs held and dispensed at the premises.

"I should have told the addicts to go back to their prescriber to obtain a new prescription so that I could give them the methadone in larger quantities," he told the Committee.

But he said he had got to know the addicts over the years and trusted them when they explained they would be unable to collect their drugs on a daily basis because they had been offered work.

"It was stupidity and laziness that is my only excuse. I got too close to the patients and that is no defence," he added.

He went on to explain that at the time he was under pressure in his private life, as his wife had been pestered by a stalker. "There was no criminal intention on my part whatsoever," he said.

Pharmacy inspector Susan Melvyn said that since Mr Kanani's court appearances she had visited the Bestwood shop and had been "impressed" with the changes that had been made.

Currently she had no complaints about the way the pharmacy was being run.

Counsel for the pharmacist, David Arronberg, commented: "He is a contrite man who has truly learned his lesson. He has done his level best to get his business running as a proper business. He gives valued service to the community and is trusted by doctors to look after a major number of addicts."

The Committee decided that Mr Kanani was guilty of misconduct but concluded the case with a reprimand.

Chairman Lord Fraser of Carmyllie QC said: "We were particularly impressed by the evidence of Mrs Melvyn and the testimonials submitted."

A simple way to cut through congestion

The new Galsud decongestant range makes it quick and easy for you to select the right product for effective nasal decongestion. So your customers can start to feel the relief.

Galsud Tablets. Abbreviated Prescribing Information
Presentation Round, convex white tablets containing Pseudoephedrine hydrochloride BP 60mg per tablet. Indications For the relief of nasal, sinus and upper respiratory congestion. Dosage and Administration For oral administration. Adults and children over 12 years: One tablet every four hours as required. Do not exceed four tablets in 24 hours. Children 6-12 years: Half a tablet every four hours as required. Do not exceed two tablets in 24 hours. Children under 6 years: Not recommended. Contraindications Hypersensitivity to pseudoephedrine, or any of the other ingredients; patients with severe renal impairment or patients receiving MAOIs or within two weeks of discontinuation. Warnings Caution should be used in prescribing the drug for patients with cardiovascular disease including hypertension, those with diabetes, hyperthyroidism, raised intraocular pressure, prostatic enlargement, bladder dysfunction or renal impairment. Interactions Caution should be exercised with patients receiving other sympathomimetic agents, appetite suppressants or amphetamine type agents. Pseudoephedrine may antagonise the pressor effects of antihypertensive agents; severe hypertension may occur in patients receiving beta-blockers. Hypertensive crisis may occur if pseudoephedrine is co-administered with MAOIs. There may be an increased risk of arrhythmias if pseudoephedrine is co-administered with cardiac arrhythmias, palpitations, hypertension, nausea, vomiting and headache in some patients. Sleep disturbances and hallucinations rarely. Erythematous nodular patches, have been rarely associated with pseudoephedrine. Legal category P. Licence Number PL 00240/0107. Pack size 100ml Price £7.14 (6). Date of Preparation 15 June 2004. Further information is available from Thornton & Ross Ltd. Linthwaite, Huddersfield, West Yorkshire HD7 5QH UK

Galsud Linctus. Abbreviated Prescribing Information
Presentation Each 5ml contains Pseudoephedrine hydrochloride BP 30mg. Indications For the relief of nasal, sinus and upper respiratory congestion. Dosage and Administration For oral administration. Adults and children over 12 years: 10ml every four hours as required. Do not exceed four doses in 24 hours. Children 6-12 years: 5ml every four hours as required. Do not exceed four doses in 24 hours. Elderly: Adult dose as appropriate. Contraindications Hypersensitivity to pseudoephedrine, or any of the other ingredients; patients with severe renal impairment or patients receiving MAOIs or within two weeks of discontinuation. Warnings Caution should be used in prescribing the drug for patients with cardiovascular disease including hypertension, those with diabetes, hyperthyroidism, raised intraocular pressure, prostatic enlargement, bladder dysfunction or renal impairment. Interactions Caution should be exercised with patients receiving other sympathomimetic agents, appetite suppressants or amphetamine type agents. Pseudoephedrine may antagonise the pressor effects of antihypertensive agents; severe hypertension may occur in patients receiving beta-blockers. Hypertensive crisis may occur if pseudoephedrine is co-administered with MAOIs. There may be an increased risk of arrhythmias if pseudoephedrine is co-administered with cardiac arrhythmias, palpitations, hypertension, nausea, vomiting and headache in some patients. Sleep disturbances and hallucinations rarely. Erythematous nodular patches, have been rarely associated with pseudoephedrine. Legal category P. Licence Number PL 00240/0109. Pack size 24 tablets Price £10.20 (6). Date of preparation 31 May 2003. Further information is available from Thornton & Ross Ltd. Linthwaite, Huddersfield, West Yorkshire HD7 5QH UK.

Comment from the Editor

Our question to pharmacists this week was: Will your pharmacy be ready for the Disability Discrimination Act which comes into force on October 1?

"Probably not because I'm not fully aware of what the regulations say"

Anon, Redbourn, Hertfordshire

"Yes, I think we have everything in place"

Anon, Rednal, Birmingham

"When they start complaining I will look at it"

Anon, Redhill

"Not particularly, I know very little about it"

Mr McLaughlin, Redcar

You wait 10 years for a bogus drug to come along and then two appear within a fortnight.

While it is easy to regard the two cases of counterfeit drugs as insignificant – and no real harm to patients has been identified – the implications are significant.

For a decade, the UK's regulatory procedures have done an excellent job in ensuring the integrity of medicines supply. But the discovery of at least 29 packages of fake drugs in the UK supply chain suggests the defences have been breached. We have to hope that it is an easily repaired pinprick that has let in the odd dribble rather than a rupture that is about to give way to a flood.

The MHRA should be praised for being as open as it can about events without jeopardising the investigation; the RPSGB acted swiftly too in offering support. Both highlighted the need for pharmacists to be vigilant about their stock.

The event makes the case against reusing returned medicines which we all know should not happen, but is a practice continued by some unscrupulous pharmacists, judging by sporadic Statutory Committee cases. Publicity about the fakes could also make the public hesitate before buying drugs over the internet.

As for Pfizer, it has been a bit disingenuous in citing concerns about medicines authenticity in Europe when it really wants to prop up US sales. But with an ever-expanding European Union, with increasingly leaky borders, the company could have a point.

This coupled with the Government's open endorsement of online pharmacies, makes it clear that significant resources will be needed to police all aspects of the drugs supply chain. Otherwise it could open the way for a tragedy.

Publicity about the fakes could make the public hesitate before buying drugs over the internet

Yourviews

New contract, new services, but...

...do your customers know, asks Pharmacy Channel MD Nainish Bapna?

The new contract compels pharmacy to offer new services, but do your customers know? You are spending a lot of time, energy and money in preparation, but it's wasted unless customers are told. Use the new contract as an opportunity to make more money from existing customers and to win new customers.

Multiples, with large budgets and teams, will be shouting from the rooftops. But independents, who have the best relationships with their customers, need to be just as aggressive.

It's your business so you can't rely on anyone, least of all the Government, to ease the burden they are placing. Patients' instinct is to go to the doctor for blood glucose testing, help with quitting smoking, cholesterol management and so on. You must tell them you are now their first port of call.

You have two tremendous strengths. Customers trust you. And they come to you to have their prescriptions filled. So, maximise the time when they are 'captive' in your store by telling them about your new services, from which you will generate more revenue.

You are busy dispensing and your counter staff are working flat out already. Leaflets, while full of all the essential information, can be boring and not many patients see them, let alone read them.

In-store television allows pharmacies to communicate with customers in a refreshing and informative way. Our AdScreen is a highly distinctive unit that fits the professional image of your pharmacy. Messages displayed in rich multimedia have a high impact so customers will be educated about health matters and ask about your services.

Pharmacists found that having in-store television increased the number of requests for services, such as smoking cessation and diabetes testing, nine-fold and revenue improved accordingly.

Only by telling your customers how much more their local independent can do for them will you reap the rewards.

HOSPITAL REPORT

Primary secondary overlap

The recent announcement (*C&D, August 14, p4*) that Boots is to provide a "full hospital pharmacy service" to a trust in the north of England raises a series of questions.

First, my understanding is that it is not a full hospital service, but only medicines supply. Where are the staff to come from? Will they be existing Boots employees, NHS employees, or is it open to all?

Will it be standard Boots terms and conditions of employment, including staff discount card, bonuses and other benefits? Or standard NHS, with NHS pension and little in the way of other benefits? Or a hybrid of the two? Whichever way, the door is open for equal pay arguments with comparators of the NHS or other Boots employees.

The trust had better be prepared for its drugs bill to increase

Will the standards of service be the same as for the rest of the NHS? How wise is it to separate the clinical side from the supply side, and how will the two work together?

Will Boots be eligible to use any of the NHS buying agreements? Doubtful. What multinational company is going to sell its products at NHS discount to a competitor? The trust had better be prepared for its drugs bill to increase!

Unlike *Xrayser* (*C&D, August 21, p17*), I do not see this as "a great idea". It will, though, be interesting to see if it can be made to work. Patients must have access to medicines, and if the local NHS doesn't want to do it, someone must.

Reversing the roles, though, would *Xrayser* support those acute hospital pharmacies having 24-hour services being automatically eligible for full NHS dispensing contracts?

Written by a senior hospital pharmacist

TOPICAL REFLECTIONS

New contract – for richer or for poorer

Will I be better off under the new contract or not? Rather worryingly, no one seems to know. I only hope there is an element of political double-talk in Sue Sharpe's statement that she doesn't know if contractors will be financially better off. If she's not sure, then presumably nobody is.

David Wood's 'guestimate' of £100 million (*C&D, September 4, p6*) would be as much as I'd hoped for. Assuming about 15,000 pharmacies, that would be about £6,500 each. And I could still negotiate with my PCT for payments for enhanced services. I wouldn't be putting a deposit on a yacht just yet, but my business could stay afloat for the foreseeable future.

I'm still undecided about my consultation room, however. If the new £1.7 billion includes funding for consultation areas, should I wait for implementation before building commences so I can claim back the money? Or can I claim for work already carried out? If all pharmacies are to receive an earmarked sum of money, will it be compulsory for them all to have a consultation area?

The new deal doesn't give much hope for the workforce of the future because of the lack of money for pre-registration training. Who but the largest multiples will think it worthwhile to fund this training? And where will all the graduates from the new schools of pharmacy do their pre-reg?

The shortage of pharmacists could become worse, particularly bearing in mind that many advanced and enhanced services will require locum cover. It would be a shame if we have a great contract in place but a lack of pharmacists to make the most of it.

Are we all sitting comfortably?

I love it when I see a pharmacy-based story in the national press. It puts my area of interest, which often seems a little narrow and introspective, into the more important context I think it deserves. As with most news stories they're usually 'bad' news, and some of the technical inaccuracies make me cringe, but they often provoke interesting customer queries that allow me to display my broader knowledge.

The clozapine "war" (*C&D, September 4, p12*) was a particularly interesting case in point, provoking a large article in last weekend's *Observer*. The piece took the predictable 'David and Goliath' angle, where big bad Novartis bullies the small, enterprising Denfleet. Unusually for the national press, however, the journalist had asked three eminent pharmacists their opinion on the matter. Two came down on the side of Denfleet's Denzapine and the third (who the article suggestively tells us is married to a senior Novartis employee) puts an argument in favour of the larger company. Fascinating story. No patients have yet mentioned this to me; however, the involvement of the OFT may provoke more interest.

While I'd love to discuss it with them, as a humble community pharmacist I wouldn't be able to shed any light on the matter other than talking generally about the issue of branded and generic drugs. I wish I had more inside knowledge and I could entertain my customers with a gripping tale that would really get them interested in pharmacy politics.

BP, RIP

A few years ago the *British Pharmacopoeia* was commonly seen adding gravitas to dispensary shelves. But I have not purchased a copy for a number of years and keep the 1988 edition largely as a souvenir. Today's needs are met by slimmer publications and corporate drug information departments. At £800 a go, the *BP* is an expensive luxury I can't afford.

I can't help feeling a little nostalgic, however, for those looks of awe from patients as I flicked through the impressive volume. And my shelves of plastic ring binders and paper folders seem so lightweight in comparison. This swapping of style and substance for efficiency has been a financial necessity rather than a fashion choice.

Chewing the fat

The launch of an over the counter version of simvastatin at the end of July was heralded by pharmacists, but roused concerns in others. We asked the Consumers' Association to spell out its worries and turned to GP Dr Ian Banks to respond

The Consumers' Association sticks by its claim that statins should stay POMs...

The Government argues that its decision to make the statin Zocor (simvastatin) available over the counter is all about providing consumers with choice and convenience.

This makes the assumption that the public is fully informed of the potential benefits and harms from taking statins in this way. But in reality, this information is not available because no specific clinical trials have investigated the intended use: long-term self-treatment with OTC Zocor 10mg daily by those deemed to be at moderate risk of coronary heart disease. Nor is there any experience of such OTC use from other countries.

The absence of this knowledge means the public is being exploited for commercial gain while being unwitting guinea pigs in a mass experiment.

In addition, there are other concerns surrounding the decision to make Zocor available OTC.

Firstly, such provision could jeopardise public health. Usually, before statins are prescribed by a doctor, the patient's liver function tests and serum cholesterol concentrations are checked. But there are no such requirements for the OTC provision of Zocor. Nor is there any set requirement for monitoring a patient once they are on the statin. And it should not be forgotten that people who choose to measure their own cholesterol levels will incur additional expense – an obvious disincentive.

Secondly, there is a lack of trustworthy information for patients. The Medicines and Healthcare products Regulatory Agency (MHRA) has posted questions and answers for patients about the reclassification of simvastatin 10mg on its website.

However, the MHRA has a low profile, so it is unlikely that the general public will be aware of the site. In any event, the information provided by the MHRA is incomplete. For example, it underplays the fact that taking Zocor OTC represents an experiment. It also ignores potentially harmful interactions of statins with grapefruit juice and certain vitamin supplements.

Thirdly, the shifting of cost could lead to unacceptable inequalities. Making a treatment available OTC shifts the cost of any benefit away from the NHS to individual members of the public.

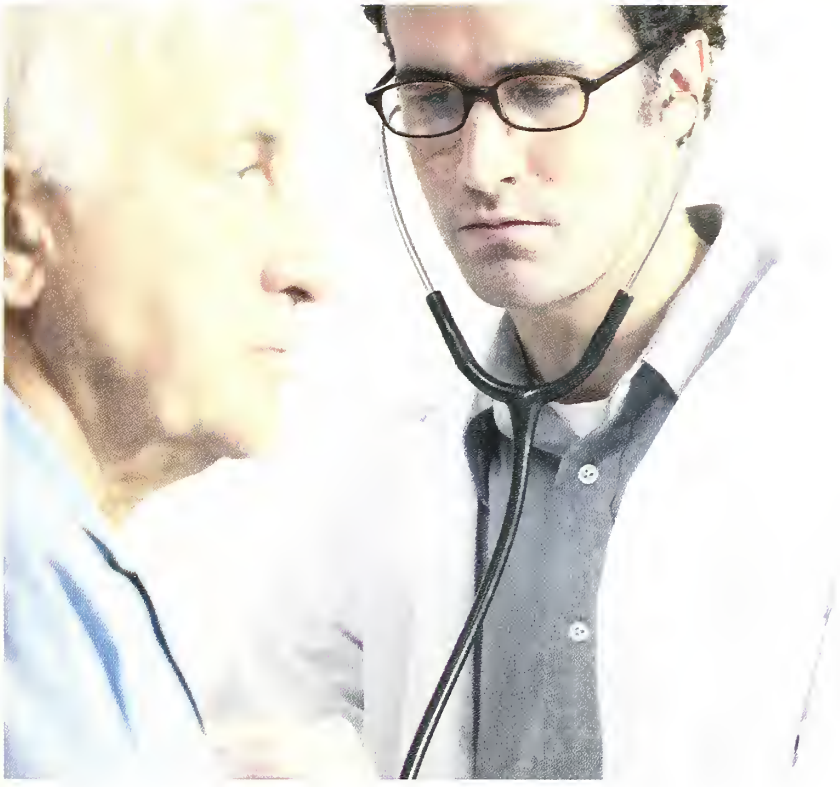
So, assuming that OTC Zocor offers a true benefit, its availability could lead to a two-tier system in which only those who can and are willing to pay enjoy potentially life-saving treatment, while other people lose out.

Certain side effects of statins are considered rare, but are highly dangerous (eg rhabdomyolysis). But as statins have not previously been available OTC, the true potential for such effects – and the impact they have on individuals – might not have emerged.

Of note, since the Government announced its decision about OTC Zocor, the Consumers' Association has received several messages from people who have become very ill as a consequence of prescribed statin therapy. They feel very strongly that statin use should remain under the direction of doctors.

For more information:

www.which.net



The case for statins

GP Ian Banks defends the decision to make statins OTC...

When pregnancy tests first became available from pharmacists there was an uproar from the BMA. Women needed doctors to guide them through pregnancy testing.

At the time this essentially meant male doctors, as female incursion of general practice was only just taking off. With each advance in patient choice and use of their own commonsense came prophecies of the end of the world as we know it. So far the shift from POM to P has gone without any major loss of life, terrorist attacks on pharmacies or mass emigration of MBs to the land of MDs.

Zantac is a good example. There were fears that undiagnosed gastric cancer would increase with a resulting higher mortality. For unclear reasons the incidence and deaths from gastric cancer have actually fallen. Enter the debate over statins.

Without doubt there is a Government agenda of reducing costs to the NHS, its track record confirms this, but many of the objections to OTC provision are not based on cost but rather lack of information available to patients and that 'only doctors' can make decisions on prescribing and advice. This flies right in the face of the increased role of pharmacists and the shift toward patient self-responsibility for their own health.

If there is insufficient information on which patients can act then the answer is to address this lack rather than apply fatalism. Yes, the MHRA is not the most well known source of information for patients, but there are alternative providers, not least NHS Direct. If the advice available is either insufficient or inaccurate it also needs attention.

Whether or not OTC provision of statins presents a risk to public health is another matter. The whole point about taking a statin is that irrespective of your cholesterol levels there are identifiable advantages.

A cholesterol check becomes even less of a pre-requisite and may well encourage people not only to seek such a test, valuable in identifying lifestyle risks or genetic predisposition, but also ask for information about the whole area of cardiovascular disease.

Men in particular are poor users of GPs in this area. Quoting such rare conditions as rhabdomyolysis is not only unhelpful but misleading as it is not associated with Zocor to any major degree. Anecdotal 'several messages' to the Consumers' Association is hardly a basis for serious medical concern given the huge number of prescriptions for statins and the information already amassed regarding safety not least because 10mg, the proposed on sale dose, was initially used for years as the recommended starting point for treatment.

Finally, the provision of OTC statins does not stop any doctor from prescribing them. What we should be looking at is not the increased choice for patients via OTC, but the Hobson's choice where PCTs are so cash-strapped by lack of government funding they are not prescribing statins in anywhere near the levels set out in evidence based guidelines.

Worse still, despite this Government's stated commitment to abolishing inequalities, postcode prescribing not only prevails, it continues to increasingly divide the nation into those who have heart disease prevention and those who have not.

For more information:
www.menshealthforum.org.uk

Reader Reply

Technicians' indemnity

Further to last week's news item, 'APTUK advises members on PI cover', (*C&D, September 4, p6*) I am writing to offer further clarification on advice offered by the Association of Pharmacy Technicians UK in relation to potential liabilities in the workplace.

I was pleased to see that our advice to all pharmacy technicians – to consider legal defence and/or professional indemnity insurance – was made clear at the very start of the news item.

However, the latter half of the article inferred that the chances of an individual pharmacy technician being sued are small because the employing organisation would have insurance. Whilst this is mentioned in our policy under 'vicarious liability and employees', further recommendations are given for locums, self-employed and contracted pharmacy technicians where, as non-employees, they are potentially at increased risk. I hope this clarifies the context of the Association's advice which was produced, along with a range of insurance options for pharmacy technicians, precisely because of these risks.

A summary of advice is available from *www.aptuk.org*

Darren Leech
President, APTUK.

CD registers

The NPA need look no further than New Zealand for a practical CD register, which provides room for all CD dispensing information, stock movements and running balances (*C&D, August 7, p4*).

It is more user-friendly than the UK system, and by law only requires a six-monthly stocktake to be done to check balances and account for any discrepancies.

Because running totals are entered at each dispensing, it is easy to spot when an error occurs, and it is certainly not a chore to keep up-to-date, unlike the badly-designed booklets and unwieldy folders used here in the UK.

Deborah Wakenshaw
MRPharmS,
Chelmsford.

Tutorial No 30

C&D Chemist & Druggist

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TENA

Incontinence

THE COLLEGE OF PHARMACY PRACTICE

This tutorial has been designed to meet the requirements of the College of Pharmacy Practice in providing one hour of postgraduate education towards the College's continuing education requirement

Incontinence is a common problem affecting around six million people in the UK. One third of us will suffer from such a problem at some point in our lives

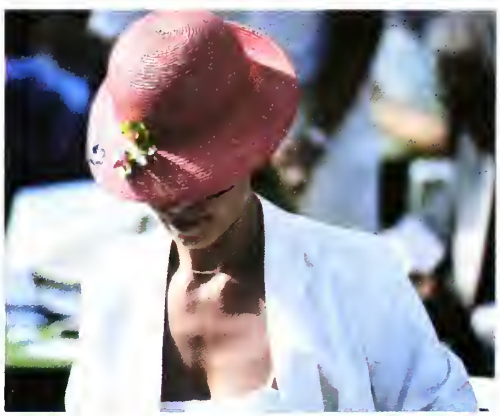
Objectives

- To understand the causes of incontinence in men and women
- To know how lifestyle changes can help symptom control
- To know which pharmacological treatments are used
- To be aware of what further treatment is available
- To recognise the community pharmacist's role as information source

Incontinence doesn't simply affect the elderly, but anyone at any age. Women are more likely than men to experience bladder problems – the Continence Foundation estimates that women make up 85 per cent of those affected – but the type of problem can vary depending on age, sex, medication, pregnancy or pre-existing medical conditions.

There are lifestyle options and treatments available, but many people are embarrassed to admit they have 'waterworks' problems and make do with sanitary products that are inadequate for their needs. Many will put off seeing a health professional for advice as they feel the problem 'is not very great' and they may wait for over 12 months before seeking help.

Incontinence is defined as "the inappropriate involuntary passage of urine, resulting in wetting". A healthy bladder gently expands as it fills with urine and the stretch receptors within the bladder send a message to the brain indicating a need to void. When it is appropriate to empty, a message is sent from the brain to the bladder allowing the sphincters to relax and the bladder to contract.



Problems with detrusor or sphincter muscles are causes for urge and stress incontinence. Depending on the extent of muscular problems and age, symptoms can vary from the occasional leak of a drop or two of urine during exercise, to complete evacuation of the bladder. There are different types of incontinence, the main ones being stress, urge, overflow and mixed.

Stress incontinence: the commonest type of incontinence and seen most frequently in women, with those in middle age (40–49) the most likely time to experience it. Here the urinary sphincter and the pelvic floor muscles are not strong enough to contain urine in the bladder; leakage may occur when the abdomen is under extra pressure from activities such as laughing, sneezing or exercise. It is especially common during pregnancy and after childbirth as these put strain on the pelvic floor muscles. Excess weight, the menopause or a chronic or smoker's cough can aggravate the problem.

Urge incontinence: instead of relaxing, detrusor muscles contract prematurely as the bladder fills which creates an urgent desire to pass water, and sufferers may fail to reach the toilet in time. This is the commonest type of incontinence in men and the elderly.

Overflow incontinence: urine may dribble out as if the bladder was overflowing either after urinating or at any time. This can be caused by a narrowing of the urethra, constipation, nerve damage from conditions such as multiple sclerosis or, in men, a non-cancerous enlargement of the prostate gland obstructing outflow. This is called benign prostatic hyperplasia (BPH) and is especially seen in men over 55. An atonic bladder can also cause overflow incontinence. This is where the bladder muscles fail to contract sufficiently to empty the bladder completely, which results in leakage. The initial symptoms of overflow incontinence can be a hesitant or slow urine stream when urinating.

Mixed incontinence: this is a combination of stress and urge incontinence and its likelihood increases with age. Neurological conditions such as MS, spinal injury, stroke and Parkinson's disease can also cause incontinence. Incontinence is not something to accept as "just one of those things", or inevitable as a part of growing old. There are methods to help sufferers approach a cure or, at worst, better manage their condition.

Diagnosis

Sufferers should seek specialist advice for a proper diagnosis of their type of incontinence. This can be done by urodynamics – techniques that record the pressures within the bladder and the urinary sphincter. This can determine how the bladder behaves when under stress from increases in pressure. Some hospitals may perform specialised x-rays or ultrasound to capture video of the bladder. Others may have access to a new technique called ambulatory urodynamics. This is a small device worn by the patient for a few hours to monitor bladder activity in more normal conditions.

Men who consult their GP with urinary problems may be examined to determine if BPH is the cause. This may include physical examinations of the abdomen and prostate, a urine test to check for infection and blood tests for kidney function and prostate specific antigen levels. Further tests could include an ultrasound to determine how much urine remains in the bladder after urination and a urine flow test measuring volume and speed.

Lifestyle interventions

Half of incontinent women manage their condition with the help of protection such as incontinence pads. These are specially designed to cope with varying volumes of urine, unlike sanitary towels. Users can decide between pads or pants and as well as unisex products there are specific male and female varieties.

Absorbency ranges from those to cope with light flow of a few drops or splashes usually stress incontinence, to mild for heavier drops normally for stress or overflow incontinence, to moderate for involuntary gushes associated with urge incontinence and heavy for complete loss of bladder control.

For customers who are unsure which product suits their needs best, or for current users wishing to check they are using the most suitable product, the National Continence Checkup is available in pharmacies this autumn to help them make an informed choice (for more information visit the Tena website.

Pharmacists are ideally placed to offer sensitive, professional advice to this group of customers. In addition, pharmacists can also be a source of further information and are well placed to make an assessment from a customer's product buying habits whether they may benefit from a suggestion to approach their GP for a referral to a specialist local continence service. Many users are unaware that further options such as pelvic floor exercises, drug therapy, and surgery for the most severe cases, exist. In the meantime, pharmacists should advise sufferers to consider losing weight (if necessary), reducing caffeine and alcohol intake, smoking cessation and on using the right protective product to help manage their condition.

Non-drug treatment

A common and widely successful technique for dealing with incontinence is pelvic floor exercises. These may take a few weeks, even months, before they deliver a substantial improvement, but they are effective for between 65–80 per cent of women. For maximum benefit a qualified practitioner such as a physiotherapist or a continence nurse specialist should teach this technique, as they can suggest extra techniques to reinforce the exercises. Men can also benefit from pelvic floor exercises.

Bladder retraining may be useful for those with urge incontinence or an overactive bladder. The technique's aim is to educate the bladder into tolerating greater volumes of urine by learning to suppress or ignore the desire to urinate. It is best done under the guidance of a continence nurse specialist or a physiotherapist.

Drug treatment

Pharmacological interventions are currently available for urge incontinence and benign prostatic hyperplasia. Antimuscarinic drugs such as oxybutynin and tolterodine can reduce the involuntary detrusor contractions which cause urge incontinence, but these are linked to side effects such as dry mouth, constipation, blurred vision and are unsuitable for use by the elderly. Flavoxate has less marked side effects, but consequently is less effective than oxybutynin and tolterodine.

Newer antimuscarinics such as propiverine, solifenacin and trospium are also licensed for urge incontinence. The first drug indicated for stress incontinence – duloxetine – has recently been approved by the Medicines and Healthcare products Regulatory Agency.

Several drug treatment options are available for men with BPH. Finasteride is an anti-androgen that inhibits the 5 alpha-reductase enzyme, which converts testosterone into dihydrotestosterone, thereby reducing prostate size and the obstruction causing the problem. It does have side effects, though, including possible impotence, ejaculation disorders, breast tenderness and enlargement. Selective alpha-blockers such as alfuzosin, doxazosin, indoramin, prazosin, tamsulosin and terazosin relax the smooth muscle at the neck of the bladder and around the prostate increasing urinary flow and improving obstructive symptoms. This class of drugs can produce such side effects such as drowsiness, hypotension (especially with the first dose of prazosin), fainting, weakness, headache and a dry mouth.

Surgery

There are several surgical options available to treat BPH, but they are generally only used in severe cases or if the prostate gland is particularly large. Surgery can often result in ejaculation problems, such as retrograde ejaculation (ejaculation into the bladder), and fertility is affected.

Women can also undergo surgery for incontinence (usually stress incontinence), receiving techniques such as tension-free vaginal tape which supports the bladder neck and the urethra, transurethral procedures or injection of bulking agents such as Teflon, collagen and silicone. These are injected into the urethra wall to improve the sealing mechanism, but can cause tissue damage and migrate over time reducing effectiveness.

For further information:
www.continence-foundation.org.uk
www.prostate-research.org.uk
www.tena.co.uk
Tel: 0870 3330874 Pharmacy helpline

Test your understanding

Test your understanding by answering the following questions, then check your answers by phoning our Telephone Marking Service on **08705 800 287** for an immediate result. You will be asked for the Tutorial Number. This tutorial is No.30. Just listen to the instructions and press buttons 1 or 0 to indicate your answers. "1" indicates true; "0" indicates false. Please note that calls are charged only at standard national rates.

This module will also appear on the *C&D* website, *www.dotpharmacy.com* under 'Education' until October 12, 2004.

If you pass this module, and you are a pharmacist or an assistant and want the appropriate certificate for this College of Pharmacy Practice accredited course, complete the form below and send the original (or a photocopy) to: Mary Prebble, Pharmacy Editorial Projects, CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW before October 12, 2004. Please enter your name and status (please tick), pharmacy, address, phone and RPSGB/PSNI number below:

Name

Address

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1 Incontinence affects about one million men and women in the UK
❑ True ❑ False

2 In a normal bladder the detrusor muscles relax to enable it to pass urine
❑ True ❑ False

3 BPH is a cancerous condition that causes incontinence in men
❑ True ❑ False

4 Stress incontinence is common in women who have given birth and can be due to weakened pelvic floor muscles
❑ True ❑ False

5 There are no pharmacological treatments available for urge incontinence
❑ True ❑ False

6 All incontinence pads are unisex and one-size-fits-all
❑ True ❑ False

7 Dry mouth is a possible side effect of finasteride
❑ True ❑ False

8 Both men and women can benefit from pelvic floor exercises
❑ True ❑ False

9 Losing weight, stopping smoking, limiting caffeine and alcohol intake can help improve incontinence symptoms
❑ True ❑ False

10 Mixed incontinence is a combination of urinary and faecal incontinence
❑ True ❑ False

Signing off

Legal technology expert **Louise Fullwood** looks at the hurdles that still need to be overcome to allow the electronic transfer of prescriptions (ETP)

Currently in England and Wales Prescription Only Medicines and all NHS prescriptions can only be dispensed against a prescription signed in ink by an authorised practitioner.

However, the UK Government, as part of its reform of the NHS, is keen to press ahead with introducing a secure system for the electronic transfer of prescriptions (ETP).

The Medicines and Healthcare Regulatory Authority has recently proposed amending the law to allow for ETP and is currently seeking the views of interested parties on the use of advanced electronic signatures.

The proposal follows a series of successful pilot schemes undertaken last year on behalf of the Department of Health. As well as being technically viable, the pilot schemes concluded that ETP had the potential to reduce prescription fraud, would be widely welcomed by stakeholders and did not raise any major security issues.

This is not to say that implementing ETP will be plain sailing. The Government recognises that there may be cost implications in complying with the proposed changes but, as ETP will be an option rather than a requirement, this may not be a decisive factor. Security and integrity, on the other hand, certainly will be.

For ETP to work, an electronic signature must be able to exhibit three features:

- verify who sent the prescription
- ensure the person signing cannot later deny doing so, and
- be capable of detecting any changes to the prescription post-signature.

Given this level of security, it has been proposed that only 'advanced electronic signatures' may be used on prescriptions electronically transmitted. An advanced electronic signature is one which:

- is uniquely linked to the signatory
- identifies the owner
- is created using a means that the signatory can maintain under their sole control and
- can ultimately detect any changes to the data.

A simple electronic signature does not have these security features.

Maintaining integrity is key. However, this can only be achieved if practitioners protect and keep secret their passwords for system access. If colleagues start sharing passwords with colleagues, use easily guessed passwords (such as spouse's name), and if passwords are not required to be changed regularly, the system could be open to abuse.

Any ETP system would also need to ensure the confidentiality of the information of the data being transferred. The prescription data would likely include details of the patient, their address and, potentially (from the nature of the drugs being prescribed), their condition.

Both the *Data Protection Act 1988* and the *NHS Confidentiality Code of Practice* require that patient data is kept private and secure. Furthermore, under the 1988 Act, the controller of the data is required to ensure that adequate security measures are in place in respect of anyone processing that data. However, such needs are certainly achievable with today's technologies.

The technological challenges may not be insurmountable but, given the potential expense and the usual resistance to change, why is the Government so keen to push ETP through?

The convenience to patients, especially the elderly, disabled and mothers of young families, is a major factor. At present, several pharmacies provide a mail order service but, under current law, patients must still present their hard-copy prescription to pharmacies before medicines can be dispensed.

Under the proposed regime, an electronic prescription could be sent from the GP to a pharmacy which could then arrange for this to be delivered directly to the patient's home.

It is, however, interesting to note that, of the four ETP systems reviewed in the pilot projects, three of which involved live trials, only one did not require that the patient obtain a paper script of some description which they were required to present to the pharmacist at the point of delivery.

The Government estimates that prescription fraud costs the country £100 million every year. Electronic prescriptions cannot physically be stolen and are not so easily subject to fraud. Mistakes caused by illegible or incomplete prescriptions and the use of confusing abbreviations and acronyms should also be reduced.

Electronic prescribing records can also be integrated with other NHS IT functions – such as the NHS Care Records Service. This should improve record keeping and help prevent adverse drug interactions where a drug may be prescribed by a practitioner who is not aware that a patient is already taking a drug which may interact badly.

The amendments being proposed by the MHRA should be welcomed as an efficient means of allowing ETP in qualifying circumstances and updating the current law in this area to reflect technological progress.

For many, success or failure of ETP will largely depend on winning the hearts and minds of the key stakeholders. Having a system in place which is safe, reliable and ultimately hacker-proof, will go a long way towards achieving that.

Contact the MHRA to comment on the proposals.

Louise Fullwood is an associate in the Technology and Media Group at leading UK law firm Pinsents.
louise.fullwood@pinsents.com
www.pinsents.com

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Nappy changing is a frequent part of daily life for anyone with a young baby and with an average of six changes per day, a convenient and hygienic disposal solution is a must!

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Now, as a result of positive consumer research, CeDo Ltd is bringing further innovation to the nappy disposal bag category with the introduction of a new flexible pack for Nappy Sacks™.

The flexible pack is new and unique to Nappy Sacks™ and new to the nappy disposal bag market. Nappy Sacks™ retain all of its existing product benefits whilst bringing to the category a point of difference from current available products.

This every change essential not only locks in any nasty niffs and germs but the new waterproof pack has the added advantage of being able to wipe off any unexpected spillages. The stronger pack is also crush resistant making it ideal for use when travelling.

The new look Nappy Sacks™ flexible pack is:

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Trade Contact: Robinson Care - Tel: 01909 735000.

In our second article on the Disability Discrimination Act, the RNID reveals deaf and hard of hearing people face restricted access to NHS services

Not **loud** but clear

In March 2004 the findings of *A Simple Cure* were released by RNID. It was the most comprehensive national survey of deaf and hard of hearing people's experience of the health service, by the largest charity representing the needs of the nine million deaf and hard of hearing people in the UK.

The results paint a worrying picture of a health service that has yet to make the changes necessary to include the needs of deaf and hard of hearing people and comply with the Disability Discrimination Act.

Over 800 deaf and hard of hearing people responded to RNID's survey about accessing healthcare services. Over a third (35 per cent) of deaf or hard of hearing people had been left unclear about their condition because of communication problems with their GP or nurse. As a pharmacist, when you dispense drugs, communicating the correct requirements of the prescription is of vital importance.

For British Sign Language (BSL) users, the communication barriers are significant. Alarmingly, a third (33 per cent) of British Sign Language users were left either unsure of the correct dosage of medication to take, or in fact had taken too much or too little medication, because of a communication problem with their health professional.

Jean, from London and deaf, recalled the time her daughter had her tonsils out. She said: "The nurse gave me a very complicated list of medicines. I think there were about four medications." Not wanting to risk her young daughter's health she asked the nurse to repeat the information but the nurse "looked exasperated" and acted as if Jean was "dim-witted". Jean said: "I wrote a letter of complaint to the pharmacy department and expressed my concern about how vital it is to make sure that patients, or parents of patients, get information clearly."

This is just one example of where simple adjustments to ease communication have not been made. At the root of all these problems is a lack of basic deaf awareness and being aware of the needs of people with disabilities has always been relevant to deaf and hard of hearing people.

It is essential to understand the obligations that are now placed upon all service providers by the *Disability Discrimination Act 1995 (DDA)*. The DDA states that when providing goods and services to the general public it is unlawful to refuse to serve a deaf or disabled person, or to provide a service of a lower standard or on worse terms to a deaf or disabled person. Clearly, in the delivery of healthcare this is critical, especially when dispensing drugs. Communication is key.

Dr John Low, chief executive of RNID, comments: "The NHS can easily address this situation with simple and cost effective solutions. Minor investment in simple technologies such as visual alert displays and loop systems will improve access and help lower the number of missed appointments. However, to be truly effective this investment needs be followed by deaf awareness training for all frontline NHS staff."

Basic deaf awareness techniques

In order to improve communication with deaf and hard of hearing patients there are certain steps you can take that will ease communication. These techniques are just some of the methods you could use, but it is important to remember that deaf and hard of hearing people all have different preferred communication methods. Remember that even if someone uses a

hearing aid, they may need to lip-read as well.

- Ask your patient/customer how they prefer to communicate and mark their notes so that other staff are aware as well.
- Ensure that your immediate environment is as quiet as possible.
- Face each other so that your patient/customer can lip-read you.
- Stand or sit as close as is polite.
- Position yourself with your face to the light and avoid placing yourself in front of a bright window. This will enable the deaf person to obtain the best view of visual clues such as body language, facial expressions and mouth movements.
- Remember to speak clearly, maintaining a normal rhythm of speech.
- Don't shout.
- Avoid jargon and unfamiliar abbreviations.
- Sentences and phrases are easier to understand than isolated words. If a word or phrase is not understood, use different words with the same meaning or if that fails, try writing it down.
- Make sure a pad of paper is at hand in case you or your patient/customer needs to write anything down.
- Remember to keep hands, pens and instruments away from your face while speaking.
- Check that your patient/customer has understood you properly.
- Approach the patient/customer when the prescription is ready, or alert them through a visual display; do not shout out their name.

Using technology to its best advantage

It is possible, with the use of technology, to improve communication with deaf and hard of hearing people. Installing induction loops for people with hearing aids at reception desks and training staff in the use of textphones will go a long way to help.

RNID Typetalk is a national telephone relay service that could be used by deaf and hard of hearing customers to phone your pharmacy to discuss medication and prescriptions. Textphone users dial direct using the 18001 prefix before the number of the person they would like to speak to and an RNID Typetalk operator joins the line to relay the conversation. In addition, new technologies such as video interpreting are available at minimal cost and these services will help ensure compliance with the DDA and greatly improve the deaf or hard of hearing customer's experience of using your pharmacy.

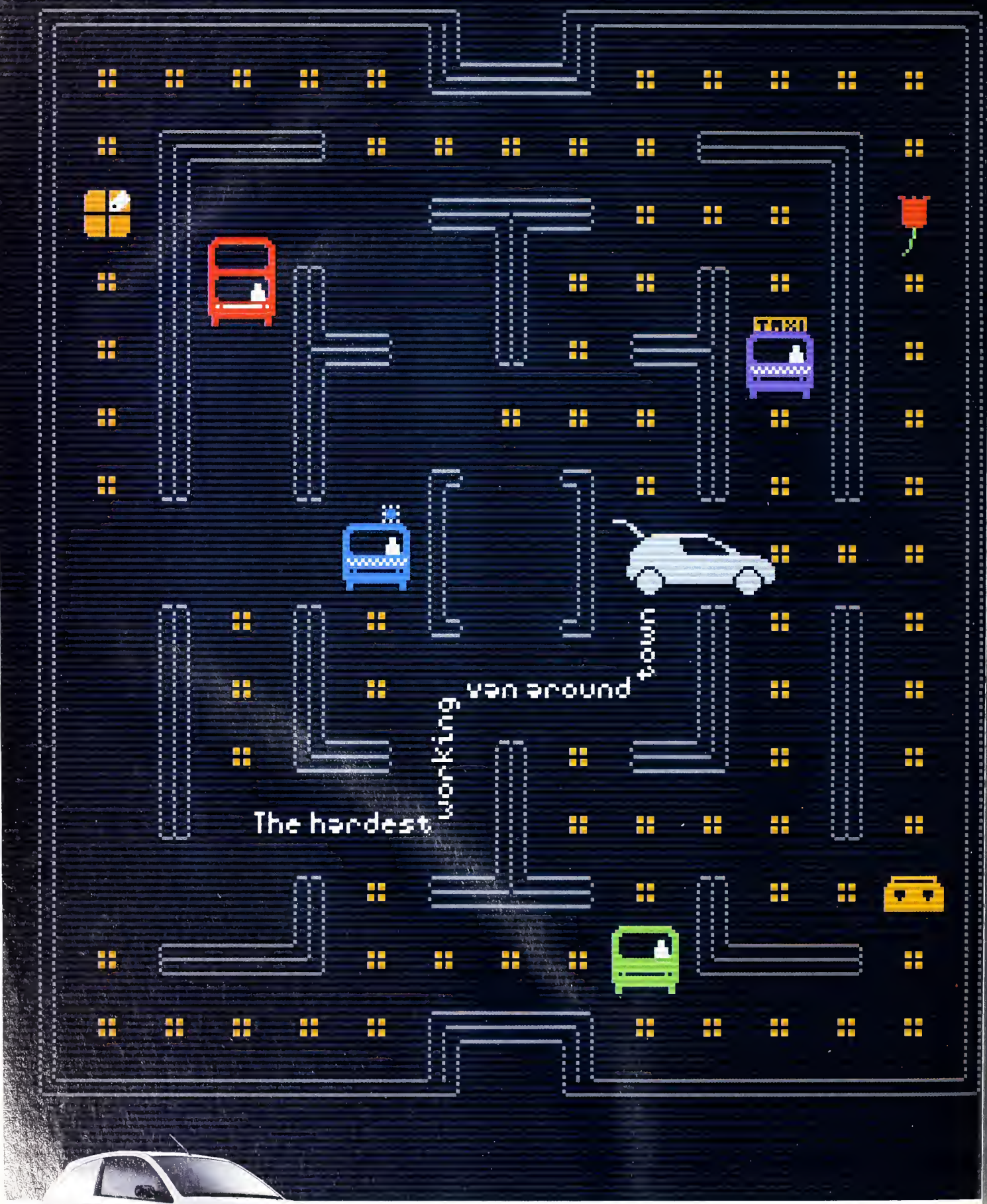
A Simple Cure makes several recommendations for changes to ensure that the health service meets the needs of its nine million deaf and hard of hearing users. These include:

- Widening the use of existing technology, including visual alert displays and loop systems.
- Deaf awareness training for all medical and nursing undergraduates.
- The NHS to instigate training seminars to ensure all GP surgeries and hospitals have at least one front-line member of staff who has been formally trained in deaf awareness and practical communication skills.
- RNID is also talking to every major authority delivering health services throughout the UK, on what changes they need to implement in order to provide a truly equal standard of service to deaf and hard of hearing people.

Communicating the correct requirements of the prescription is of vital importance for pharmacists and pharmacy staff

For more information please contact the RNID information line on 0808 808 0123 or visit *www.rnid.org.uk*, *www.rnid-typetalk.org.uk*

100 years of Ford



Start. Foot down. First pick up. Thumbs up to plenty load space. Stop. Traffic lights. Go. Nip up narrow alley...oops, wrong way. Appreciate tight turning circle. Stop. Off load. Go. Avoid traffic cop. Well played. Bonus points for driving zippy new Fiesta Van. Stop. For more information call 08457 111 888 or visit www.fordvans.co.uk/fiestavan

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Ford

Vanessa Sherwood MRPharmS describes the symptoms and management of endometriosis

The vicious cycle

THE COLLEGE OF PHARMACY PRACTICE
This course (module 1314), in association with multiple choice questions being published in *C&D* October 2, provides one hour's continuing education

- To be able to define endometriosis
- To recognise symptoms in women seeking advice
- To be aware of how the condition is diagnosed and the problems with diagnosis
- To be aware of the rationale and side effects of treatment
- To offer support and advice to sufferers

Endometriosis is a women's condition where cells that normally line the uterus – the endometrium – are found in other parts of the body, usually within the pelvis. Endometrial tissue has also been found in the bowel, the bladder, in operation scars and even in the lungs.

Although the endometrial tissue is not in the uterus it is still controlled by the monthly hormonal cycle. Each month the tissue builds up and then breaks down and bleeds – the same way as the lining of the uterus does if there is not implantation of a fertilised egg.

Unlike a period, blood lost from endometrial deposits has no way of leaving the body and can lead to inflammation, pain and the formation of scar tissue. In the ovaries, endometrial tissues can cause cysts, which may be known as chocolate cysts because of their appearance.

As well as pain, endometriosis can lead to fertility problems.

Adenomyosis is a related condition where the endometrial tissue has infiltrated the wall of the uterus.

Prevalence

Recent research suggests that the prevalence of the condition is around 10 per cent of women of child-bearing age.[1] The National Endometriosis Society (NES) estimates that two million women in the UK have endometriosis.[2]

Endometriosis can occur at any time from the onset of periods (menarche) until the menopause. For most women endometriosis ceases at the menopause.

A suspected increase in the incidence of endometriosis could be due to changing reproductive habits: epidemiological studies have shown that women who have not had children are more likely to develop endometriosis.

The condition also shows a genetic link, with first-degree relatives showing a 5-7 per cent recurrent risk.

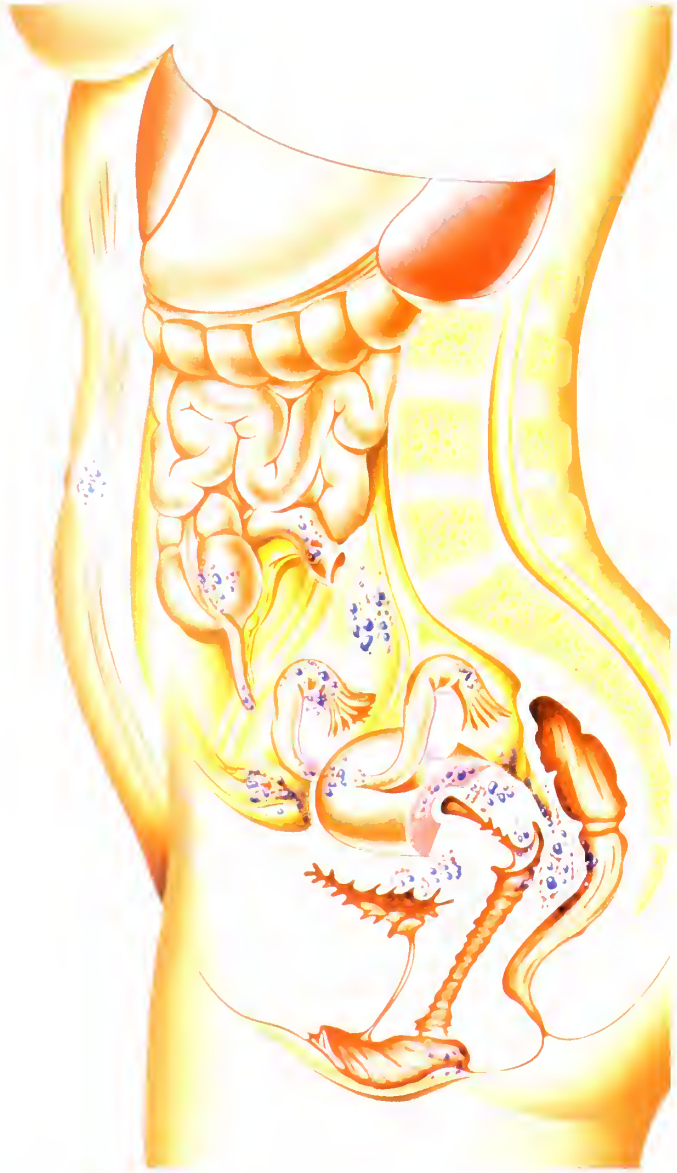
Symptoms

Dysmenorrhoea – but the pattern of pain may be different from normal period pain, building up before bleeding starts and then remaining as a more diffuse pain in the lower abdomen during the period.
Pelvic pain
Lower abdominal pain or back pain
Dyspareunia (painful intercourse - during or after sex)
Dyschezia (pain on defecation)
Loin pain
Pain on micturition
Pain on exercise
Lethargy
Extreme tiredness.[3]
Some women with endometriosis have no symptoms at all and the degree of pain does not appear to be related to the amount of endometriosis but to the location of the deposits.

Causes

Theories put forward include:
- Retrograde menstruation (*see below*)
- Lymphatic/circulatory spread
- Genetic predisposition
- Immune dysfunction
- Environmental causes such as exposure to toxins.

Continued on page 28 ▶



JOHN BAVOSI/SCIENCE PHOTO LIBRARY

Illustration of the organs inside a woman's abdomen, showing sites where endometriosis can develop. Endometriosis occurs when fragments of the lining of the uterus are displaced to other parts of the body and continue to grow. Possible sites are shown in blue

The most widely accepted theory is retrograde menstruation. Instead of passing out through the vagina in the normal way, menstrual blood travels back along the Fallopian tubes and into the pelvis. Endometrial cells in this flow attach to the reproductive organs or other tissues. Why endometrial deposits develop in some women and not others is unclear.

Investigations have implicated disturbances in the immune response as fundamental to the aetiology and pathogenesis of endometriosis. However, it is not clear to what extent this involvement is a primary response leading to the initiation and progression of the disease or a secondary response to the ectopic endometrial growth in an attempt to restore homoeostasis.[4]

Diagnosis

The only effective way to diagnose endometriosis is by a laparoscopy: the insertion of a rigid viewing instrument to look inside the pelvis or abdomen through small incisions. Occasionally a laparotomy (abdominal incision) may be needed if the endometrial deposits are hidden deeper and tissue needs removing. Scans, blood tests and internal examinations are normally inconclusive.

Although laparoscopy is the gold standard for diagnosis, the need for this invasive diagnostic tool is a major stumbling-block in both effective clinical management and for research into the condition. Also, because of NHS cost constraints, not every patient in primary care suspected of having endometriosis can be sent for laparoscopy.

Advantages of laparoscopy over laparotomy include a reduced hospital stay, quicker recovery and less pain for the patient.

The wide and variable range of symptoms may also be associated with other conditions such as pelvic inflammatory disease or irritable bowel syndrome, making diagnosis difficult.

An NES survey showed the average time between reporting symptoms and receiving a diagnosis was seven years, with some women referred to other specialists before a gynaecologist.

Treatment

Treatment should be individualised according to factors such as the patient's age and reproductive desires, extent of disease, severity of symptoms, response to previous therapies and anticipated side effects.

The aim of treatment is to reduce pain, to increase the possibility of pregnancy and to delay recurrence for as long as possible.

Whether medical or surgical treatment should be chosen is controversial.[5] Some physicians suggest medical treatment as a first line, reserving surgery for those in whom medical treatment has failed or for patients with severe disease. Others suggest that the emphasis on medical treatments leads to inadequate treatment and management in the long-term, and that surgery is appropriate for all patients.

The primary goal of surgery, to treat pain or infertility, is the removal of endometrial deposits and the restoration of normal pelvic anatomy. Surgery may range from a mild, cytoreductive technique via laparoscopy or laparotomy to a complete hysterectomy with removal of both ovaries. Medical and surgical treatment may be combined in some cases.

The medical treatment of endometriosis is more relevant for community pharmacists and includes analgesia and hormonal treatments.[6]

Analgesics

Dysmenorrhoea in women with endometriosis is treated in the same way as dysmenorrhoea generally: an NSAID to reduce pain – for example, ibuprofen 400-600mg three to four times daily with or after food, or mefenamic acid 500mg three times daily. Where NSAIDs are not tolerated or are contra-indicated, paracetamol or co-codamol can be used as alternatives.

Severe pain and vomiting may occur in endometriosis, requiring additional treatment with an anti-emetic such as prochlorperazine or domperidone.[7]

Hormonal

The aim of hormonal treatments is to reduce the size of endometrial deposits either by altering the effect of oestrogen on the endometrial tissue or by reducing oestrogen levels.

All the current treatments appear to be effective at reducing symptoms but symptoms often recur after treatment is stopped.

Combined oral contraceptives: although not licensed to treat endometriosis, in younger women who also require effective contraception, the COC pill reduces endometriosis-associated dysmenorrhoea and can be taken for longer than other hormonal treatments. There is no evidence that one COC is more effective for dysmenorrhoea than another – obviously low-dose oestrogen (20-35mcg ethinyloestradiol) preparations are preferable. They may be used continuously or cyclically, as usual.

Progestogens: for example, medroxyprogesterone acetate 10mg three times daily for 90 days; dydrogesterone 10mg two to three times daily from day five to 25 of the cycle or continuously; or norethisterone 10-15mg daily for four to six months. Progestogens suppress secretion of the pituitary gonadotrophins (follicle stimulating hormone [FSH] and luteinising hormone [LH]), thereby leading to a hypo-oestrogenic environment and inhibiting ovulation. Side effects include irregular bleeding, bloating, mood changes and weight gain.

Anti-progestogens: danazol inhibits pituitary gonadotrophins. It is given 200-800mg daily in up to four divided doses, adjusted to achieve amenorrhoea, usually for three to six months, to a maximum of nine.

A symptom of endometriosis is pain in the lower abdomen during a period

It also has androgenic activity and inhibits ovarian oestrogen production.

Gestrinone has similar actions to danazol but has a longer half-life. The former is taken 2.5mg twice weekly starting on the first day of the cycle with the second dose three days later, repeated on the same two days and preferably at the same time each week; duration of treatment is usually six months.

Gestrinone is also supposed to be better tolerated than danazol because it is less androgenic, but both drugs can cause weight gain, hirsutism, acne, headache and occasionally deepening of the voice.

Gonadorelin analogues: gonadotrophin-releasing agonists – eg buserelin, goserelin, nafarelin, leuprorelin and triptorelin – produce an initial stimulation of FSH and LH release. Continued administration is followed by down-regulation of gonadotrophin-releasing hormone receptors, reducing the release of FSH and LH which, in turn, leads to inhibition of androgen and oestrogen production. This pseudo post-menopausal state is associated with menopausal symptoms such as hot flushes, increased sweating, vaginal dryness and loss of libido. The decrease in bone density (4-6 per cent over six months) limits their use to a maximum of six months, or two three-month treatments (unlicensed use).

Add-back hormone replacement therapy (conjugated oestrogens with progestogens) can reduce menopausal symptoms without reducing the effectiveness of treatment, but its effects on bone density are unclear.

The choice of hormonal treatments is guided by adverse effects and desired length of treatment.

Associated symptoms

Sub-fertility: There is a well-established link between endometriosis and infertility. In severe cases the anatomical distortions of the pelvis caused by deposits are an obvious cause of infertility.

If endometrial deposits are removed, there is no permanent damage to the lumen of the Fallopian tubes (compared with an infection which may cause permanent damage) and conception is more likely.

In women who are symptom-free, endometriosis may only be discovered during infertility investigations.

The link between mild or moderate endometriosis and infertility is less clear in these cases and there seems to be more controversy about the best way to treat these patients, despite guidelines from the Royal College of Obstetricians and Gynaecologists.

Cancer: Epidemiological evidence from large-cohort studies confirms endometriosis as an independent risk factor for ovarian cancer. Molecular studies have also detected common alterations in endometriosis and ovarian cancer. However, endometriosis-associated ovarian cancer represents a distinct clinical entity with better survival rates than non-endometriosis-associated ovarian cancer.[8]

Future developments

Efforts are being made to improve the diagnosis of endometriosis by investigating the use of high-resolution transvaginal ultrasonography and magnetic resonance imaging techniques.

There is also much research into new medical treatments.[9]

Mifepristone has been shown to be effective in some studies. In endometriosis it acts as an antiprogestogen that inhibits ovulation and disrupts endometrial integrity.

Gonadotrophin-releasing hormone antagonists work in a similar way to the agonists but do not cause an initial stimulation of hormone release, theoretically offering quicker relief of symptoms. Phase III trials are examining some of these compounds for efficacy and side effects compared with agonists.

Aromatase inhibitors may also have potential benefits as the endometriosis produces its own oestrogen via the aromatase enzyme. These compounds have been successfully tested in rodent models but substantial bone loss is a concern.

Other drugs being researched include inhibitors of the cytokine TNF-alpha and angiogenesis.

Pharmacist role

Community pharmacists should encourage women who are regularly buying OTC analgesics for dysmenorrhoea to see their GP to investigate their symptoms. It is also important to ensure that analgesics are being used in appropriate doses to provide the most effective pain relief.

Women who have been sent away from their GP having been told "it will be better when you've had a baby" or that "it's just period pain" should also be encouraged to persevere in their requests for treatment or referral.

Pharmacists advising women who are having difficulty conceiving should remember to ask about the nature of the woman's period.

Those who regularly suffer with severe pain following the endometriosis pattern should again be referred to the GP for further investigation.

Above all, it would appear that women with endometriosis suffering with regular severe dysmenorrhoea and possible infertility need a sympathetic, supportive approach.

The National Endometriosis Society.
Tel: 020 7222 2781 or
www.endo.org.uk

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Vanessa Sherwood is a freelance writer and formerly clinical editor for C&D.

Actionplan

1. Revise the changes that occur in the body during the menstrual cycle. Pay particular attention to the changes in the hormones involved and how they affect both primary and secondary female sex organs.
2. Try to find out from women you know well enough to discuss this personal subject, how the menstrual cycle affects them (in any way, including physiological and psychological).
3. Are you aware that any of your clients suffer from endometriosis? What medicines are they prescribed to help control this condition? Are they the same as those mentioned in the article? If not, think about the rationale of prescribing them.
4. Have any of your clients had surgical treatment for endometriosis? Was it successful?
5. In your practice workbook list the symptoms of endometriosis that may be presented to you as a pharmacist. Consider this list whenever a female presenting with one or more of these symptoms asks you for advice. May the cause be endometriosis? Should you refer?

Distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education can be tested to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their learning by answering multiple choice question (MCQ) paper to be inserted in the October 2 issue, and will be the weekly CPP-accredited topics together with those in the September 18 and 25 issues. These will cover:

- **Endometriosis (1314)**
- **Incontinence (1315)**
- **Vitamin D (1316).**

A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Mary Pibble on 1730 377269.

in association with

GENUS PHARMACEUTICALS

Montelukast role for periodic child asthma

Montelukast could have a role for treating infrequent periodic asthma in children, an Australian researcher announced at last week's European Respiratory Society conference.

The PRE-EMPT trial, which is yet to be published, found that parent-initiated montelukast at the first sign of asthma symptoms in children aged two to 14 could reduce the number of cases needing medical attention and reduced the time off school, or work for the parents.

The once-daily tablet administered by parents was convenient and avoided the need for remembering correct inhaler technique, which can be a problem when a child is an infrequent sufferer, said researcher Dr Nicholas Glasgow.

There were no differences between side effects from the placebo or active groups, added Dr Glasgow.

The study also examined the effect on direct and indirect costs, and found that montelukast use lowered the amount spent on other asthma medications, healthcare resources (including GP visits, attending A&E or admission to hospital) and parent work loss.

A once-daily tablet of montelukast could make the inhaler unnecessary

Adjustable dose is best for asthma

Adjustable dosing for asthma reduces the burden of the disease compared with fixed dosing, researchers announced at this week's European Respiratory Society congress.

The researchers compared use of Symbicort (budesonide/formoterol) with adjustable and fixed dosing, and Seretide (salmeterol/fluticasone) with fixed dosing only. Despite no significant difference between the treatments, they found a 40 per cent decrease in the rate of exacerbations with adjustable dose Symbicort compared with fixed dose Seretide, and a 32 per cent reduction compared with Symbicort fixed dose.

Over the seven months of the study, the patients achieved similar levels of asthma control irrespective of which treatment they were taking.

Glasgow GP John Haugney said: "This adjustable dosing method has proven benefits to patients in terms of symptom and exacerbation control."

DTB criticises ezetimibe

No compelling evidence exists to suggest Ezetrol (ezetimibe) lowers the risk of heart attacks, claims the *Drug and Therapeutics Bulletin*.

Ezetimibe is under attack for its manufacturers' claim that it can prevent heart attacks

The drug should be reserved for patients with homozygous familial hypercholesteroaemia or sitosterolaemia, says *DTB*, but manufacturer MSD-Schering-Plough condemns this statement as preventing access for those whose cholesterol is uncontrolled by statins alone and are at high risk of a cardiovascular event.

DTB says evidence exists that adding ezetimibe to statin therapy does lower cholesterol levels more than statin monotherapy. However, it claims evidence does not exist to back up the companies' claims that ezetimibe can prevent heart attacks or strokes.

MSD-Schering-Plough responded by saying evidence exists showing "lower is better" for cholesterol levels and the drug helps 72 per cent of patients "get to goal" when statins alone didn't achieve this.

For more information:

DTB 2004; 42: 65-7

Exercise for healthy heart

Fitness levels may be better predictors of cardiovascular events in women than obesity, claim researchers from the USA.

Despite overweight women in the study being more likely to have heart disease risk factors, neither BMI nor abdominal obesity measures were statistically significantly associated to cardiovascular events.

However, women who scored poorly on a physical fitness scale were significantly more likely to have risk factors, say researchers in the recent issue of the *Journal of the American Medical Association*.

The authors conclude fitness might be a more important marker for cardiovascular risk in women than obesity and interventions to increase exercise levels should be included in managing all women at risk of heart disease.

For more information:

JAMA 2004; 292: 1179-87

Galantamine no use for chronic fatigue

Galantamine does not confer any benefit over placebo in treating chronic fatigue syndrome, say researchers from the UK.

After 16 weeks of galantamine treatment at doses of 2.5mg, 5mg, 7.5mg and 10mg or placebo, none of the 434 patients showed any improvement in their chronic fatigue syndrome.

There were no statistically significant differences between the treatment groups and the placebo group.

The researchers claim in the latest issue of *JAMA* that galantamine's failure to improve symptoms may indicate that cognitive deficits associated with chronic fatigue syndrome may not be due to cholinergic dysfunction.

Galantamine is currently indicated in the UK for treating mild to moderate dementia in Alzheimer's disease.

For more information:

JAMA 2004; 292: 1195-1204

Scriptlines

ZD list has additions

PSNC has announced that the Department of Health has added the following products to the Zero Discount list in October's *Drug Tariff*.

List A (no endorsement required):
Salbutamol 200 Cyclocaps (salbutamol 200mcg inhalation powder capsules)
Salbutamol 400 Cyclocaps (salbutamol 400mcg inhalation powder capsules).

List B (if no discount has been received, endorse the prescription ZD):
Vernagel Sachets.

For more information:

www.psnc.org.uk

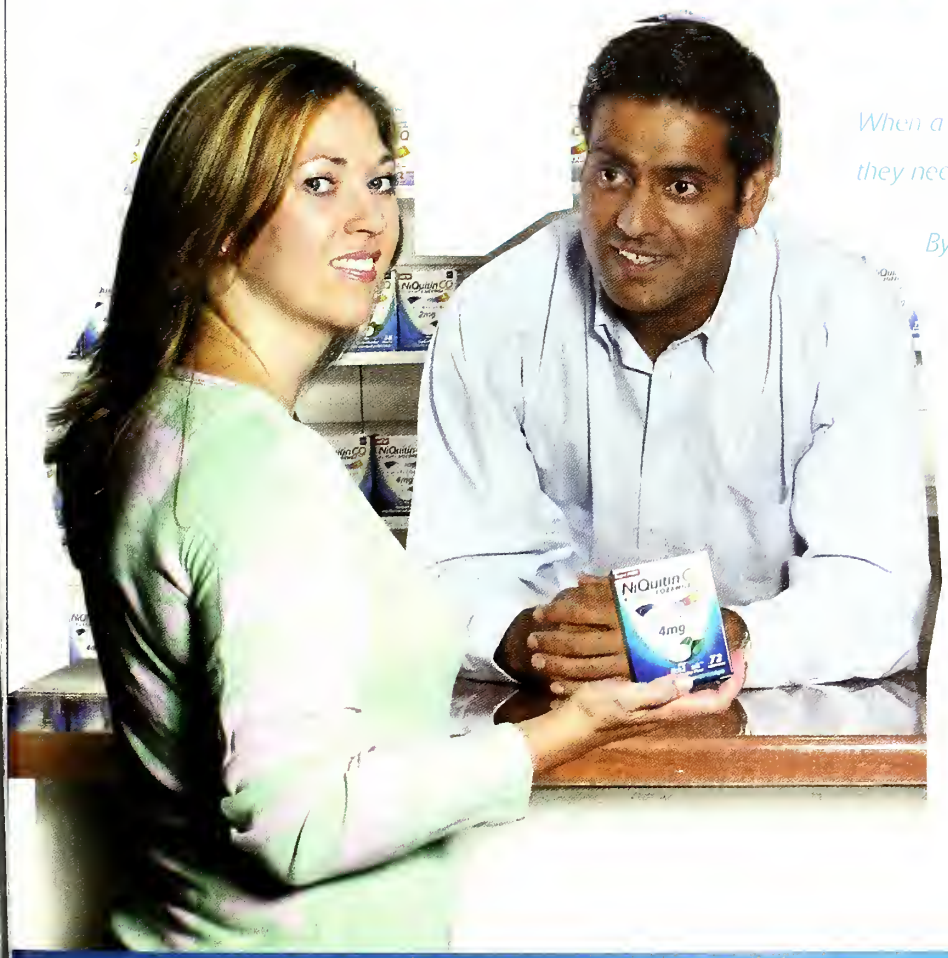
Easyhaler launch

Ranbaxy has launched Easyhaler (salbutamol) 100mcg and 200mcg, multidose dry powder inhalers.

Price: £3.46, 309-3465, 100mcg; £6.92, 309-3457, 200mcg

Ranbaxy
Tel: 020 8280 1600

If I'm serious about quitting, I'd better get some serious help.



When a customer sets out to quit smoking, they need more than just the NRT you sell.

By recommending NiQuitin CQ 4mg Lozenge, you'll not only be offering them highly effective craving protection, you'll also be giving them the opportunity to get clinically proven behavioural support from the Click2Quit Stop Smoking Plan.

Quittin' with NiQuitin

Customers can visit Click2Quit.com for their personal quit plan

Nicotine

iQuitin CQ 2mg/4mg Lozenge and Mint Lozenge **icotine)** for relief of nicotine withdrawal symptoms during noking cessation. **Dosage:** *Adults only:* 4 mg if smoke within 30 inutes of waking. 2 mg if longer. Stop smoking completely eeks 1 to 6; 1 lozenge every 1 to 2 hours (min. 9 max. 15/day), eeks 7 to 9; 1 lozenge every 2 to 4 hours, weeks 10 to 12, 1 enge every 4 to 8 hours. Weeks 13-24, 1 to 2 lozenges per day ly when strongly tempted to smoke. **Contraindications:** on-smokers, those under 18, PKU, recent MI/stroke, severe hythmias, unstable/worsening /resting angina, hypersensitivity **ecautions:** Hypertension, peptic ulcer, severe kidney/liver impairment, phaeochromocytoma, hyperthyroidism, diabetes, cardiovascular disease, low sodium diet. Swallowed nicotine may exacerbate oral/pharyngeal inflammation, oesophagitis, gastritis, peptic ulcer. **Interactions:** Concomitant medication may need dose adjustment. **Side effects:** Depression, irritability, anxiety, insomnia, headache, dizziness, cough, cold. Nausea, hiccup, flatulence, GI disturbance, appetite change, oral irritation/ ulceration, nightmares, restlessness, mood change, pharyngitis, thirst, taste/sensory disturbance, dyspnoea, respiratory disorders, rashes, itching, sweating, numbness, flushes, vascular disorders, halitosis, chest pain, throat swelling, leg oedema, pain, malaise, wakefulness, palpitations, tachycardia, tooth/jaw ache, nocturia. **Pregnancy/lactation:** Try without nicotine replacement therapy. Medical assessment of risk/benefit if necessary. **GSL. PL:** 00079/0369, 0370, 0373 & 0374 **PL holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Pack size and RSP:** 36's £8.99, 72's £17.49 **Date of last revision:** March 2004

Reference:

1 Strecher V *et al.* Poster presented at the 12th World Conference on Tobacco or Health, Helsinki, 3-8 August, 2003.

Frontshop

Senokot Hi-Fibre replaces Fybogel OTC packs

Reckitt Benckiser is rebranding Fybogel as Senokot Hi-Fibre for OTC sale. It is available in two variants – lemon and orange.

Senokot Hi-Fibre contains granules of ispaghula husk 3.5g in each sachet. The product is formulated to maintain regularity and gently relieve constipation.

It is targeted at people who suffer from constipation but who currently choose to increase fibre and water in their diet rather than buying an OTC product.

Dosage is one sachet or two level 5ml spoonfuls of granules in the morning and evening stirred into cold water.

Children from six to 12 can be given half to one 5ml spoonful in water morning and evening depending on their size and age. It will be supported by a £1 million national TV campaign beginning on October 18 and running until the end of the year.

All Fybogel NHS packs will remain.

Price: lemon and orange 10 sachets £2.79, orange 30 sachets £5.99

Pip code: lemon (10) 306-5216, orange (10) 306-5224, orange (30) 306-5208
Reckitt Benckiser Plc
Tel: 01482 326151

Added clout for Covonia

Thornton & Ross is launching a "flu strength" pharmacy-only expectorant-based product for colds and flu into its Covonia range.

Covonia Cold & Flu Formula contains paracetamol 1,000mg, guaifenesin 200mg and phenylephrine hydrochloride 12.18mg in each 20ml dose.

The non-drowsy liquid is formulated to offer relief from all five major symptoms of colds and flu. It is indicated for the relief of aches and pains, headache, nasal congestion, dry tickly sore throat and chesty cough.

The Covonia brand will be supported by a £2.5 million TV advertising campaign running from November to February.

Price: £4.29

Pack size: 160ml
Pip code: 302-0336
Thornton & Ross Ltd
Tel: 01484 842217

Clearasil hits the spot

Crookes Healthcare is launching a spot treatment cream which is claimed to deliver visibly clearer skin in three days.

Clearasil Rapid Action Treatment Cream contains salicylic acid and hydrogen peroxide. The new cream is targeted at teenagers.

The launch will be supported by a £6 million marketing campaign, including TV and print advertising and sampling activity.

Price: £4.99

Pack size: 30ml
Pip code: 306-5885
Crookes Healthcare Ltd
Tel: 0115 953 9922

Sensodyne targets young with new whitening paste

Sensodyne Total Care Gentle Whitening is being relaunched with an improved formulation and a new look.

The low abrasion toothpaste is formulated to remove stains gently yet more effectively to help restore teeth to natural whiteness.

The new packaging is designed to appeal to the brand's existing loyal user base.

The relaunch features a 'new improved whitening' flash and a stronger focus on the 'total' and 'whitening' propositions.

Price: 45ml tube £2.19, 75ml tube £3.35, 100ml pump £3.99

Pip code: 45ml 076-4449, 75ml 092-3722, 100ml 020-4362
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Inbrief

Fletchers update

Forest Laboratories is discontinuing Fletchers' Enemette with immediate effect due to a manufacturing problem. This does not affect any of the other Fletchers products.

For more information:

Forest Laboratories UK Ltd
Tel: 01322 550550

Essential Information

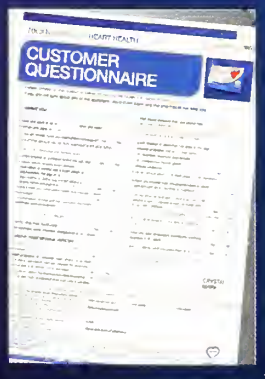
Product Name: Zocor Heart-Pro® 10mg tablets. **Presentation:** Peach-coloured, oval-shaped tablets containing simvastatin 10mg. **Indications:** To reduce the risk of a first major coronary event (non-fatal myocardial infarction and coronary heart disease (CHD) deaths) in individuals who are likely to be at moderate risk (approximately 10-15% 10 year risk of a first major event) of CHD. **Dosage and Administration:** Take one 10mg tablet daily at night. Not recommended for paediatric use. **Contraindications:** Hypersensitivity to simvastatin or any of the excipients; previous history of muscular toxicity with a statin or fibrate; individuals already taking prescription cholesterol lowering drugs; concomitant administration of potent CYP3A4 inhibitors (e.g. itraconazole, ketoconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin and nefazodone); active liver disease or unexplained persistent elevations of serum transaminases; pregnancy and breast-feeding; women of childbearing potential. **Precautions:** Zocor Heart-Pro® is not intended for individuals who are known to have: existing coronary heart disease, diabetes, history of stroke or peripheral vascular disease, familial hypercholesterolaemia. Individuals with hypertension should consult their doctor before undertaking treatment. Individuals with a fasting LDL-cholesterol level of 5.5 mmol/l or greater should consult their doctor. All individuals must be advised of the risk of myopathy and told to stop taking Zocor Heart-Pro® if they experience unexplained generalised muscle pain, tenderness or weakness. People aged >70 years or with hypothyroidism, renal impairment, personal or family history of hereditary muscle disorders should not take Zocor Heart-Pro® except on medical advice. Product should be used with caution and under medical supervision in people who consume substantial quantities of alcohol and/or have a history of liver disease. If treatment with itraconazole, ketoconazole, erythromycin, telithromycin or clarithromycin is unavoidable, therapy with Zocor Heart-Pro® should be suspended during the course of treatment. Concomitant use with potent inhibitors of CYP3A4, e.g. ciclosporin. Individuals with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine. **Side Effects:** Most commonly reported side effects were: abdominal pain, constipation, flatulence, asthenia, headache. The following side effects have also been reported: anaemia, paraesthesia, dizziness, peripheral neuropathy, dyspepsia, diarrhoea, nausea, vomiting, pancreatitis, hepatitis/jaundice, rash, pruritus, alopecia, myopathy, rhabdomyolysis, muscle cramps, myalgia. Apparent hypersensitivity syndrome has been reported rarely. Increases in serum transaminases, alkaline phosphatase and serum CK levels. **Legal Category:** P. **PL Number:** PL 13249/0039. **PL Holder:** Johnson & Johnson•MSD Consumer Pharmaceuticals, High Wycombe, Buckinghamshire HP10 9UF, UK. **Packaging Quantities:** 28 tablets. **Price:** £12.99 (RRP). **Date of Preparation:** May 2004.

A MAJOR STEP FORWARD FOR PHARMACY.

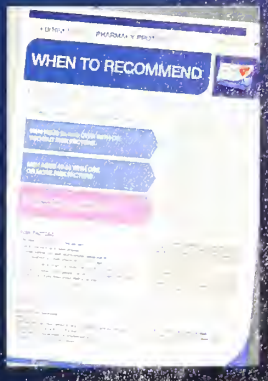
AND WE'RE RIGHT THERE WITH YOU.

Zocor Heart-Pro® is here, the first statin in the World to move from prescription-only to pharmacy. In 15 years, statins have become Britain's most prescribed drug class, with the ability to significantly lower LDL cholesterol - and reduce the risk of coronary heart disease. Now you have the opportunity to provide Zocor Heart-Pro® to customers at moderate risk of CHD as part of a Healthy Heart Programme. Zocor Heart-Pro® comes with a full support programme - to help you do the right thing for your customers. And everything you do will be helping your customers reduce their risk of a heart attack.

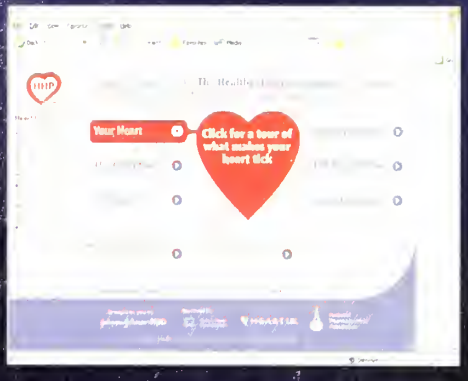
The Zocor Heart-Pro® Support Programme.



Self-completion customer forms, to help you easily identify customers at moderate risk.



You'll have a reference guide to help you know when to recommend.



You'll be able to direct enquirers to the online Healthy Heart Programme, (www.heartpro.co.uk) for further lifestyle advice and support.

CoMedis

or further information and
ansfer orders, please go to
ww.comedis.co.uk

Johnson & Johnson · MSD
CONSUMER PHARMACEUTICALS

For more product information, visit www.zocorheartpro.co.uk
or call our pharmacists' support line on 0800 032 8258

HHP
Healthy Heart Programme
www.heartpro.co.uk

Frontshop

Relax with Radox bathing beauties

Sara Lee is relaunching its Radox Herbal Bath range with improved formulations and a new look.

The range comprises six blends of natural herbs and minerals – Relax with juniper, Stress Relief with rosemary, Muscle Soak with clary sage, Sleep Easy with lavender, Moisture Soak with calendula and Time Out with mimosa.

All six products come in 500ml bottles and four of the variants also come in a value for money one litre size.

New in the Radox range are Aromatic Bath Essences which come in four variants – Spoil Me with hibiscus and jasmine, Embrace me with cinnamon and acacia, Restore Me with ylang ylang and bergamot and Calm Me with seaweed and watermint. Packaging is in a premium gold coloured bottle.

The range will be supported by a £4 million advertising campaign with national TV coverage from October 18 until November 14.

Price: Herbal Bath 500ml £1.99, one litre £3.49; Aromatic Bath Essences 500ml £2.49

Sara Lee UK Ltd
Tel: 01753 523971

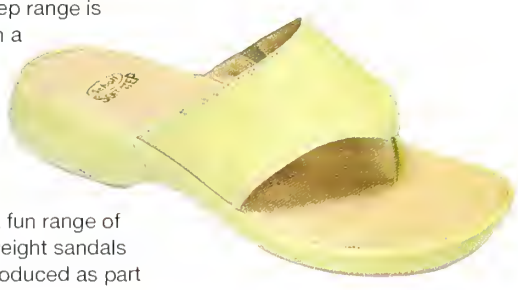
Scholl springs into action

SSL International is launching a stylish Scholl footwear collection for spring/summer 2005.

Popular colours are black, white and muted pastels used on suedes with contrasting footbeds and printed outsoles.

The Scholl Softstep range is being extended with a much younger, urban range featuring trainer style shoes, casual slip-ons and loafers as well as sandals.

'Rest 'n' Ray' is a fun range of extra flexible, lightweight sandals which are being introduced as part of the Scholl Fitness collection.



The new Adapta range (pictured) features printed flowery footbeds inspired by the revival of florals as well as more traditional styles.

For more information:
SSL International Plc
Tel: 0161 654 3025

E45 makes street debut

Crookes Healthcare is supporting E45 Moisturising Lotion with its first ever national outdoor poster campaign appearing in nearly 2,000 locations across the UK.

The activity will start on September 15 and will particularly focus on the London area.

The £1 million campaign also includes advertising in women's magazines during September and October.

The new advertisements highlight the E45 brand's heritage in the dry skincare arena with the straplines 'the dry skin specialists' and 'dry skin expertise'.

For more information:
Crookes Healthcare Ltd
Tel: 0115 953 9922

TVnextweek

Aquafresh: All areas
Astral Moisturiser: C4, five, GMTV
Bassett's Soft & Chewy vitamins: GMTV, Sat
Bisodol: Sat
Bodyform: C4, five, GMTV, Sat
Brolene Cool Eyes: GMTV, Sat
Canesten Duo: All areas except CTV
Setlers: five, GMTV
Syndol: All areas

PharmaSite for next week: **NiQuitin CQ** – window, **Heartburn Care** range – in-store, **Metanium** – dispensary

B-Border, C-Central, C4-Channel 4, C5-Channel 5, Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Grate news from Eumovate

Eumovate Eczema and Dermatitis Cream will appear in a striking new advertising campaign in women's magazines this autumn.

Three simple full-page advertisements will focus on eczema triggers. They include a woolly jumper with barbed wire around the neck and a bar of soap combined with a cheese grater to show how easily everyday things can trigger an attack. The advertising encourages eczema sufferers to ask their pharmacist for advice.

The coverage will be increased during National Eczema Week (September 18-25) with the addition of inserts in newspaper supplements.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Oral-B®
Precisely

The secret to a dazzling smile

- Your first impression is important
- **Your smile is the first thing people notice about you**
- Did you know your pearly whites may only be 60% clean
- **If you don't floss you're leaving up to 40% of the surfaces of your teeth untouched and uncleaned.**
- This can lead to gum disease, tooth loss, bad breath and a less than stunning smile
- **Hummingbird™ is a whole new way to floss – easier and less messy**
- At a simple push of the button the Hummingbird gently vibrates – it feels amazing
- **Helps you achieve whole mouth health and an incredible smile**
- The Hummingbird is powered by one AAA battery
- **Choice of two interchangeable attachments – power ergonomic flosser and soft mint dental pick**
- Clinically proven to work
- **Let the flossing revolution begin and smile with confidence**

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Frontshop

Wake up to Aquafresh on TV

Aquafresh Wakey Wakey Zones, Revive Zones and Refresh Zones toothpastes will be advertised on TV for the first time this month.

The new commercial is designed to illustrate how an everyday ritual can be converted into an exciting sensory experience.

It uses a combination of animation and live action elements to create an 'Alice through the looking glass' effect to step into the Wakey Wakey Zone.

Whilst the advertising focuses on waking up with Aquafresh Wakey Wakey Zones, it also highlights Revive Zones and Refresh Zones along with the strapline 'toothpaste with a twist.'

On air from September 13 until October 24, the TV advertising is part of a £1.43 million campaign which also includes press advertising and nationwide sampling.

For more information:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Read all about joint care

Seven Seas has published an NPA-approved training booklet on joint care for pharmacy assistants. *An introduction to natural approaches to joint care* is designed to provide a comprehensive introduction to glucosamine, cod liver oil and fish oils.

The booklet explains the nature and causes of osteoarthritis and the role that food supplements can play in treating such joint problems naturally. It is part of a Seven Seas education programme that also includes training on probiotics, laxatives and Omega 3 fish oils for the heart.

For more information:
Seven Seas Health Care Ltd
Tel: 01482 716311

Oramoist's desert strategy

Periproducts is supporting its Oramoist dry mouth brand with a £50,000 press advertising campaign.

The advertising uses imagery of the Sahara desert as a backdrop with the headline 'when your mouth feels as dry as this ... you can now take this.'

The campaign is running in the *Daily Mail* and women's weekly magazines until October. It will also appear in professional titles like *The Stage* using the message 'When you can't afford to have dry mouth.'

For more information:
Periproducts Ltd
Tel: 020 8868 1500

Happy days with L'Oreal

L'Oreal has developed a new hydrating skincare range which will be launched next January.

The HappyDerm range is formulated with extracts of cocoa bean and Indian chestnut to help promote hydration, softness and radiance.

The range comprises Super-Hydrating Skin Exhilarating Cleansing Mousse and Super-Hydrating Skin Exhilarator Moisturiser.

Both products are available in two variants – for normal and combination skin or dry and sensitive skin.

Price: cleansing mousse (150ml) £4.99, moisturiser (50ml) £6.99

L'Oreal Group UK
Tel: 020 8762 4000

Wassen supplements' natural message

Wassen is backing its range of nutritional supplements with a £1.2 million advertising press campaign this autumn/winter.

Using the message 'maintaining health, naturally,' the campaign will appear in women's magazines, national newspapers and *Reader's Digest*.

The campaign will run from October until spring 2004.

For more information:
Wassen International Ltd
Tel: 01372 379828

Pharmacy **FORUM**

Nappy rash

Advice on how to tackle nappy rash is changing. Up until now, healthcare professionals have generally recommended products to treat, rather than prevent, nappy rash. This is no longer the case as new medical research[1] indicates that it is important to protect babies' delicate skin against the causes of nappy rash by using gentle barrier ointments at every nappy change

Nappy rash is caused by the effects of irritatant chemicals in urine and faeces against a baby's delicate skin. The condition is made worse when the baby wears a tight nappy, which both chafes the skin and stops the air circulating.

Babies can be more likely to suffer from nappy rash if they are:

- Suffering from colds or infection
- Moving to solid foods
- Teething
- On antibiotics

How can it be treated?

Most nappy rash – 70% of cases[2] – is not as a result of a skin infection, merely irritation, so antiseptics and antifungals are often not needed. Many products on the market are designed solely to treat secondary infected nappy rash and can contain ingredients and medicinal antiseptics[3], which may not be suitable for everyday use.

Nappy rash prevention

- Change a baby's nappy often and allow the skin to breathe by loosening the nappy and taking it off from time to time
- Gently clean the affected area with warm water and cotton wool
- Healthcare professionals should recommend applying a gentle barrier ointment or cream, designed for every day use on the baby's skin at every nappy change[4].

References

1. PUTET G, GUY B, ANDRES P et al. December 2001. Realites Pediatriques – Effect of Bepanthan Ointment on the prevention and treatment of diaper rash on premature and full-term babies

2. CONCANNON P, GISOLDI E, PHILLIPS S et al. Diaper dermatitis a therapeutic dilemma. Results of a double-blind placebo-controlled trial of miconazole nitrate 0.25%. Pediatr Dermatol 2001; 18(2): 149-155

3. SIEGRIED E.C. Neonatal Skin Care and Toxicology. Textbook of Neonatal Dermatology, 62-72, 2001

4. BOUNTY INSIGHT/BOUNTY HEALTH NETWORK, April 2004 two-thirds of HCPs currently guide new mums to use a barrier at every nappy change

No pain no gain

Pain management consultant Dr Beverley Collett talks to Fiona Salvage about how pharmacists can advise on pain

Everyone knows what pain feels like, but everyone feels pain differently. All the time our understanding of how we learn to feel pain, how we treat different kinds of pain (eg neuropathic) and how our brains can sometimes be the origin of pain is changing our views on this common symptom.

However, familiarity breeds contempt. Do consumers know enough about pain and the pills they take for it? Or are there enough medications available over the counter? At what point should a pharmacist refer someone to a specialist or GP for further investigation? What are the new ways of treating pain are there?

Research from GlaxoSmithKline suggests that the general public do not know enough about the painkillers they take, what is in them or what side effects they might cause. Active ingredients in branded analgesics are a mystery to 70 per cent of the population and 25 per cent don't think about possible interactions with other medicines when taking painkillers.

Dr Beverley Collett, a consultant in pain management and anaesthesia at the University Hospitals of Leicester, believes pharmacists can play a role in educating the public about their chosen painkillers. Repeating dosage instructions and safety information to customers when they are buying analgesics "would be useful" as the public thinks "if I can buy it over the counter it must be safe", she says. "I think people don't realise that any medicine can potentially cause harm." She criticises the ready availability of analgesia without professional advice: "A big problem is supermarkets where you can just go and buy them [without advice]."

Another issue, recently publicised on the BBC's *One Life* programme, is non-prescription analgesic abuse. Here pharmacists "need to be slightly proactive because patients don't realise they can run into problems. If

Continued on page 40 ▶

You can't recommend a stronger painkiller.

)DUCT INFORMATION FOR NUROFEN PLUS
'ofen Plus: Each tablet contains 200mg ibuprofen Ph Eur and 12 8mg Codeine Phosphate Ph
cations: For the relief of pain in such conditions as rheumatic and muscular pain, backac gia, 'aine, headache, dental pain, dysmenorrhoea, feverishness, symptoms of colds and influenza. **Dosage and ministration:** Adults and Children over 12 years one or two tablets every four to six hours. Do not take e than 6 tablets in 24 hours. Not for use by children under 12 years of age. Elderly No special dosage ifications are required unless renal or hepatic function is impaired, in which case dosage should be assessed ridually. **Contraindications:** Patients with existing, or a history of, peptic ulceration. Hypersensitivity to any e constituents, aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs). Patients with a history of chospasm, rhinitis, urticaria, associated with aspirin or other NSAIDs. Hypersensitivity to codeine, respiratory ession, chronic constipation. **Precautions and Warnings:** Caution is required in patients with renal, ac or hepatic impairment. In patients with renal impairment, renal function should be monitored since it deteriorate following the use of any NSAID. Bronchospasm may be precipitated in patients suffering from, ith a previous history of, bronchial asthma or allergic disease. The elderly are at an increased risk of equence of adverse reactions. Undesirable effects may be minimised by using the minimum effective dose he shortest possible duration. Nurofen Plus tablets should be used with caution in those with hypotension or hypothyroidism. The tablets should be used with caution in patients with raised intracranial pressure or injury. The label will state: Do not use if you have ever had a stomach ulcer or are allergic to ibuprofen (or of the ingredients of the product) or aspirin. If you are allergic to or are taking any other painkiller, treatment, or suffer from asthma speak to your doctor before taking Nurofen Plus. Do not exceed the stated dose. Keep out of the reach of children. If symptoms persist, consult your doctor. The label will state: (On outer pack) Do not take every day for long periods of time unless told to do so by your doctor. (On Patient Information Leaflet) Do not take more than the stated dose of this medicine. Regular use for longer periods may result in symptoms such as restlessness and irritability when you stop taking this medicine. If you find you need to use this product all the time, see your doctor straight away. **Side effects:** Hypersensitivity reactions have been reported following treatment with ibuprofen. These may consist of (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, or (c) assorted skin disorders, including rashes of various types, pruritis, urticaria, purpura, angioedema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Gastro-intestinal - abdominal pain, nausea and dyspepsia. Occasionally peptic ulcer and gastro-intestinal bleeding. Renal - Papillary necrosis which can lead to renal failure. Others - Hepatic dysfunction, headache, dizziness, hearing disturbance. Rarely thrombocytopenia. Side effects of codeine include constipation, respiratory depression, cough suppression, nausea and drowsiness. **Product licence Number:** PL 03270/0082
Licence Holder: Crookes Healthcare Limited, Nottingham NG2 3AA
Legal category: P **MRRP:** (12) £2.67, (24) £5.03
Date of preparation: May 2004 NFN654

CROOKES HEALTHCARE

patients are coming in regularly for analgesics, the pharmacist should have concerns". Often patients don't realise that the painkillers they are taking can be causing the pain they are taking them for.

However, it might not be analgesic abuse. It could simply be that the patient has had pain for a while and OTC products aren't strong enough. Here Dr Collett has advice too: "If a patient has had pain for one to two weeks and they don't know what the cause is, pharmacists should refer them to their GP as they might need a different type of analgesic. Patients shouldn't go to Accident & Emergency if they have had symptoms for several weeks."

Would extending the range of analgesics available from pharmacies help? This isn't the answer, says Dr Collett. "Asthmatics have the choice of paracetamol and paracetamol-combined products. Not all get asthma induced by an NSAID, whereas in some it is induced without them being aware why.

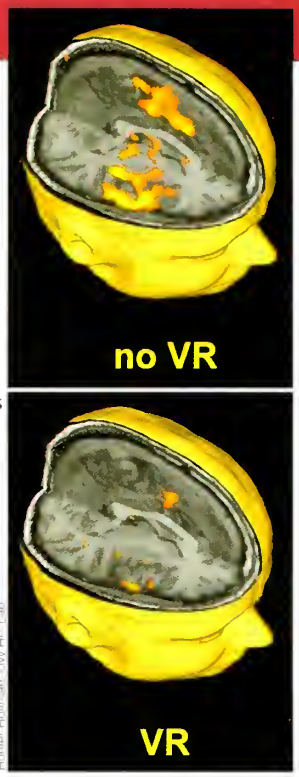
"I have certain reservations on Cox-2 inhibitors as OTC medicines. We don't know enough about them and there is a debate on safety and efficacy not sorted out yet." (*See box "Rofecoxib increases risk of MI".*)

Safety issues exist with painkillers that have been around for much longer than Cox-2 inhibitors. This week the Committee on Safety of Medicines, part of the Medicines and Healthcare products Regulatory Agency, closes its consultation on co-proxamol.

Latest research appears to show that efforts to remind users of the potential overdose risk have not reduced the number of deaths linked to co-proxamol. The drug is associated with 300-400 accidental and intentional overdoses each year, says the MHRA.

Some debate remains about whether the drug is more effective than paracetamol alone in treating pain. Dr Collett says: "Personally I do see some people in the clinic for whom co-proxamol does work. Whether it will be something to do with genetics it is difficult to say. I'd be really surprised if it was a modern GP's first choice, but I'm sure older GPs use it, as do younger GPs when other medications don't work."

Although agencies are investigating an older pain medication, researchers are looking into new techniques for dealing with pain. "We're much more aware of neuropathic pain," says Dr Collett. "This is important because NSAIDs and paracetamol are not good for treating neuropathic pain. Pharmacists can help by picking up neuropathic pain and referring patients to their GP."



Hunter Hoffman, UW HIT Lab

Virtual reality appears to change dramatically how the brain registers pain

Existing treatments for neuropathic pain include tricyclic antidepressants, some antiepileptics and gabapentin. Recently Pfizer launched pregabalin, the follow up to gabapentin, which is licensed for neuropathic pain and as an adjuvant therapy for epilepsy. Meanwhile, British company GW Pharmaceuticals awaits MHRA approval for its cannabis medicine Sativex, which is indicated for neuropathic pain and multiple sclerosis.

New drug delivery methods are helping patient compliance, says Dr Collett. "Patch technology is useful for when elderly patients don't want to have to take lots of tablets."

Pain relief could even be moving away from medication; 3-D virtual reality (VR) is a new way that physicians in the USA are distracting burns patients from painful treatment.

Although the idea of using a distraction technique to take someone's mind off pain isn't revolutionary, using VR reduces pain more than twice as much as a normal computer game. And using a specific programme called *SnowWorld*, VR works even better. Hunter Hoffman, director of VR analgesia research at Washington University, USA, says VR appears to change dramatically how the brain registers pain, not just how people perceive the pain. "It is changing the actual activity of the brain."

Results from patients who tried the *SnowWorld* programme showed the time they spent thinking about their pain dropped by 44 per cent. This was backed up by actual physical changes within the brain, where pain-related brain activity fell by 50-97 per cent (*see picture*). "In other words, the VR treatment reduced pain both in the mind and the brain," says co-author Todd Richards.

So even if there are no further pain medications switched from POM to P, maybe pharmacies can offer their customers VR pain relief in the future as an enhanced service?

For more information:
www.mhra.gov.uk
www.washington.edu

Rofecoxib increases risk of MI

Recent research from the USA adds fuel to Dr Collett's argument about not switching Cox-2 inhibitors to OTC status.

Users of rofecoxib in doses over 25mg had a three-fold increased risk of an MI or sudden cardiac death compared with remote NSAID use, claim researchers presenting at a recent International Society for Pharmaco-epidemiology meeting. An increased risk was also seen with rofecoxib doses under 25mg when compared with celecoxib use, but this was not statistically significant when compared with remote NSAID use.

Additionally, naproxen use increased the risk of a coronary event by 18 per cent and the researchers believe that indomethiacin and possibly diclofenac are associated with such an increase.

The authors conclude further research is necessary to compare rofecoxib and celecoxib, but warn that no assumptions should be made about the safety of other selective Cox-2 inhibitors.

Pharmacist Andrew McCoig said: "We have always held the view that coxibs are a better choice for the elderly because of their gastrointestinal safety profile. However, this study has shown the importance of considering the cardiovascular safety as well ... and this is something pharmacists need to be aware of when advising at-risk customers."

Market overview

Despite retail price discounting affecting the value of the analgesic market, steady volume growth on the sector has persisted through people buying and using more painkillers.

Sales of analgesics in pharmacy fell by 1.9 per cent to £180.4 million compared with last year. Pharmacy clings on to the greater share though, as grocery and drugstore sales rose by 0.4 per cent, taking it to £149.1 million. Overall the total market's value fell by 1 per cent to £329.5 million, from 2003-04.

The UK remains the largest OTC market, with 62 per cent penetration, according to the latest figures from TNS. New oral formulations offering faster pain relief or maximum strength are driving the market. These products are especially popular when consumers are going through a stressful or demanding situation, says manufacturer GlaxoSmithKline.

Women are more likely to purchase analgesics, with 57 per cent of sales attributed to them, says GSK. Research from Wyeth, the maker of Anadin, reveals that further divisions in purchasing habits exist within the UK. Its research found that people in the North are most likely to have stomach pain, whereas those in the South East suffer the most with muscular aches and pains. The Scottish are the likeliest to treat a hangover, whereas those in the West Midlands are more likely to treat a sore throat than anyone else in the country.

Despite consumers purchasing on average 5.5 analgesics each year, only 30 per cent of them knew which ingredients were in branded products. Further research conducted by GSK Consumer Health discovered 30 per cent of consumers think all analgesics work in the same way. Over half don't think about whether or not an analgesic should be taken on an

Continued on page 42

for life's little twists and turns

urce: TNS Counterpoint, July 2004

ntation: Cream containing Hexyl Nicotinate 2%w/w, Ethyl Nicotinate 2%w/w and Tetrahydrofurfuryl Salicylate 14%w/w. **Indications:** Relief of rheumatic and muscular pain and symptoms of s and strains. **Dosage and administration:** For topical application to the skin. Adults, the elderly and children: Massage gently into affected area until cream is entirely absorbed. Apply at least aily until symptoms abate. **Contraindications:** Sensitivity to the product or any of its ingredients. **Warnings:** Do not apply to broken or sensitive skin e.g. around the eyes or scrotal skin. Avoid mucous membranes. Transvasin cream is a rubefacient and within a few minutes of application a sensation of warmth is felt, followed by a reddening of the skin. This erythema does not e intolerance. Wash hands after use. Do not use with occlusive dressings. If a rash develops, discontinue use of the product. Avoid excessive exposure of the treated area to sunlight. **Pregnancy ctation:** No reports of adverse effects, however as with all medicines, care should be taken when administering to pregnant or lactating women. **Side effects:** Localised sensitisation reactions that have invariably subsided following withdrawal of the medication. **Legal category:** GSL. **Licence number:** PL 00240/0062. **Pack size:** 40g/80g. **Price:** £1.55/£2.65.

Market overview

empty stomach. Almost 40 per cent of users don't associate painkillers with stomach bleeds, the research discovered.

GP Rob Hicks says: "These results … indicate that people may not be taking the pain reliever that is most suitable for them … paracetamol remains a recommended first treatment option for pain by GPs and hospital doctors, as it can be taken by a wider group of people than NSAIDs, including people with stomach ulcers, and women who are pregnant or breast-feeding, with advice from their doctor."

Oral analgesics

Syndol is back on TV this month with a £1 million campaign, says manufacturer SSL International.

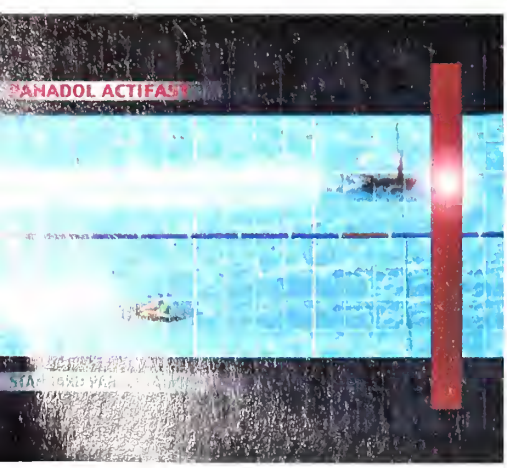
SSL hopes the ad featuring an office worker with a headache will continue to drive the product's sales of £10.5million, which it claims makes it the fastest growing adult oral analgesic.

Syndol sales are growing by 13 per cent year-on-year, making it the largest pharmacy-only oral analgesic, claims the company. Point of sale materials are available from local SSL sales representatives.
SSL International, tel: 0161 654 3000.

Panadol ActiFast is back on TV screens this month for a three-week campaign, which will be followed by a poster campaign in October.

GlaxoSmithKline is spending £1.5 million on the multimedia campaign for Panadol, bringing back the Fast Lane adverts – "this fast world causes pain, it doesn't stop for it" – which debuted last year. The posters will focus on Compack from Panadol using the "twice as fast" message.

Panadol ActiFast has seen year-on-year growth of 6 per cent since its launch two years ago, says GSK.
GlaxoSmithKline Consumer Healthcare, tel: 020 8047 5000.



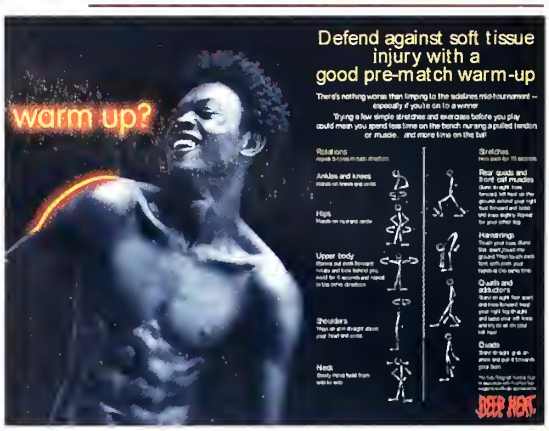
Care Ibuprofen for Children Oral Suspension recently joined the paediatrics analgesics market, costing 23 per cent less than the leading brand, says Thornton & Ross.

Care Ibuprofen Suspension has an orange flavour, is colour and sugar-free and suitable for children over six months. The product is the first in a series of three liquid analgesic launches from Care.
Thornton & Ross, tel: 01484 848200.

Customers looking for an alternative method of analgesia may find **Nectar Ease** capsules give them relief from aches and pains, says the company.

Nectar Ease contains bee venom and Manuka honey, with the Plus products also containing glucosamine sulphate, and is intended for helping with aches and pain and stiffness from arthritis. The capsules are low-sugar and are safe to use long-term, says the company.
Nectar Ease, tel: 0800 7830942.

Topical analgesics



Mentholatum is supporting its **Deep Heat** Rub and Spray and with a £1.2 million press and outdoor advertising campaign this autumn. In addition, the company is targeting sports users with a £600,000 campaign for Deep Freeze, building on last year's "touchline" campaign.

The company says Deep Freeze accounts for nearly 36 per cent of the sector value, and Deep Heat continues to dominate with a 53.1 per cent share in pharmacy. Specifically, Deep Heat Rub 100g is Mentholatum's fastest selling product in pharmacy.

Earlier in the year, Mentholatum sponsored the *Telegraph* 5-A-Side Cup, giving teams money-off coupons for Deep Heat Rub and Spray and Deep Freeze Gel and Spray.
Mentholatum, tel: 01355 848484.

This year, SSL International is supporting **Tiger Balm** with an above and below the line marketing campaign including national press and focused in-store promotions.

Tiger Balm White contains cajuput oil and peppermint oil, giving it a minty smell; Tiger Balm Red contains camphor, menthol and cinnamon for extra strength.

Applied to the skin, Tiger Balm provides symptomatic relief of muscular aches and pains and is available in 19g jars.
SSL International, tel: 0161 654 3000.

Earlier this year, Novartis launched a 50g version of its "untypical topical" **Voltarol Emulgel P**, which was in addition to the existing 30g size.

The company says the product "stands out from the crowd" because its unique formulation, combining a penetrating cream and a cooling gel, allows diclofenac to pass through the skin easily and speed recovery.

Consumer research found 92 per cent of customers who tried Voltarol would buy it again over any other brands.
Novartis Consumer Health, tel: 01403 210211.

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CROOKES HEALTHCARE

PRODUCT INFORMATION NUROFEN FOR CHILDREN Suspension containing ibuprofen 100mg/5ml. **Indications:** Prescription and OTC. For the relief and effective reduction of fever, including post immunisation pyrexia and the fast and effective relief of mild to moderate pain, such as sore throat, teething pain, toothache, earache, headache, minor aches and sprains. **Dosage:** For pain and fever: The daily dosage of Nurofen For Children is 20-30mg/kg bodyweight in divided doses. This can be achieved as follows: Infants 6 – 12 months: One 2.5 ml spoonful may be taken 3 to 4 times in 24 hours. Children 1 – 3 years: One 5 ml spoonful may be taken 3 times in 24 hours. Children 4 – 6 years: 7.5 ml (5ml + 2.5ml spoonful) may be taken 3 times in 24 hours. Children 7 – 9 years: Two 5 ml spoonfuls may be taken 3 times in 24 hours. Children 10 – 12 years: Three 5ml spoonfuls may be taken 3 times in 24 hours. For post immunisation pyrexia: One 2.5ml spoonful followed by one further 2.5ml spoonful 6 hours later if necessary. No more than two 2.5ml spoonfuls in 24 hours. If the fever is not reduced, consult your doctor. For oral administration. For short term use only. **Contraindications:** Hypersensitivity to any of the constituents. Patients with a history of, or existing peptic ulceration. Patients with a history of asthma, rhinitis or urticaria associated with aspirin or other non-steroidal anti-inflammatory drugs. **Precautions and Warnings:** [illegible] **Side effects:** [illegible] These may include [illegible] **Product Licence Number:** [illegible] **Licence Holder:** [illegible] **Legal Category:** [illegible] **RRP Price:** [illegible] **Date:** [illegible]

NUROFEN for children

IBUPROFEN

Nurofen for Children is the only paediatric analgesic to come with a syringe specifically designed for easy, accurate dosing.

For fast and effective fever relief.

Market overview

Round-up of pain research

Dendron claims its topical analgesic **4head** has "awakened a dormant need in the market" where customers previously waited before treating a headache. This information backs up its pre-launch research, it says.

Since its launch, the company says 4head has received positive responses from pharmacies and consumers.

Dendron is supporting 4head with a campaign including national press and TV advertising. In addition, point of sale materials are available from company representatives. Dendron, tel: 01923 229251.

Ibuleve is continuing to dominate the topical NSAID market with a 55 per cent market share, says manufacturer Dendron.

The first NSAID gel to go OTC, Ibuleve became the brand leader three months after the switch. Dendron's research shows two thirds of Ibuleve users are aged over 55 and 70 per cent are women. Users aged under 35 were

basing Ibuleve for transient pains such as
s injuries and injuries caused by carrying
ar heavy objects. Also available is
ximum Strength Gel, which is
individuals with backache,
d muscular pain and neuralgia.
Dend 01923 229251.

Paracetamol and the kidneys

Long-term use of paracetamol may increase the risk of damaging kidney function in women, claim researchers from Harvard Medical School.

A study of 1,697 women gave the researchers information on their lifetime use of paracetamol, aspirin and NSAIDs. Only long-term use at high doses of paracetamol was associated with a decline in kidney function; no such association was found with aspirin or other NSAIDs.

However, the decline in function some women experienced would not be "considered clinically important"; nevertheless, the authors believe that these women, if they continue to consume large amounts of paracetamol, are more likely to develop "clinically relevant renal dysfunction". Despite this, the authors warn that the potential side effects of all analgesics should be part of the treatment choice.

Of the women in the study, 177 were found to have a 30 per cent reduction in their renal function over 11 years. Of the 177, 15 per cent of those who took over 3,000g paracetamol during their lifetime experienced a decline in renal function, compared with 12 per cent of NSAID users and 11 per cent of aspirin users of similar volumes of drugs. The authors conclude, though, that the "absolute risk of renal function decline due to even high lifetime analgesic intake seems to be modest".

For more information:

Arch Intern Med 2004; 164: 1519-24

Rethinking the thinking on pain

Pain that can't be linked to a medical condition may originate from the brain, not the body, according to research from University College London.

By using hypnosis to suggest pain, the researchers identified the brain areas responding to pain without an obvious cause and discovered that they were similar to the area stimulated by physical pain. Both suggested pain and actual pain stimulated areas in the brain (thalamus, midanterior insula, parietal and prefrontal cortices) that researchers believe are linked to a pain network or neuromatrix.

The physical pain stimuli induced more pain compared with the hypnotically induced pain, the researchers say. They add further research is necessary to determine to what extent the pain is caused by hypnosis.

"The fact that hypnosis was able to induce a genuine painful experience suggests that some pain really can begin in our minds," says David Oakley, director of UCL's hypnosis unit.

Weather is to blame for migraine

The weather can be to blame for many things, but it seems that migraine is one of them, according to research from the USA.

A two-year study found over 50 per cent of patients with headaches were affected by the weather; however, 63 per cent believed that they were affected.

Those migraine sufferers who were affected by the weather were sensitive to a mixture of temperature and humidity changes, especially low temperature and humidity or high temperature and humidity. The next commonest migraine cause was a major weather change over one to two days.

The authors hope that, by paying close attention to personal sensitivity to weather, sufferers can prevent or at least be ready to treat weather-induced headaches.

Better the Devil for your knee?

Devil's claw sounds like a particularly tricky mountaineering challenge, but it may hold untold power in relieving chronic knee pain in osteoarthritis sufferers.

Researchers from Southampton University are looking for volunteers to take part in a study to determine how effective the herbal remedy is in treating OA. Preparations of the South African plant are already available to buy; the researchers hope to identify what dosage works best and how effective it is.

Volunteers must be over 40, have been diagnosed with OA in at least one knee by their GP or a consultant (but not waiting for a knee replacement joint) and have had knee pain for more than three months and every day for the past four weeks. And they must be willing to attend Southampton General Hospital eight times. Still interested?

For more information:

devclaws@soton.ac.uk

Link between touch and pain

Researchers from Sweden think they have evidence to overturn current thinking on the pain nature/nurture debate.

Professor Jens Schouenberg and co-workers claim that tactile feeling foetal movements in the womb are enough to start a learning process in the baby's pain system.

To reach this conclusion, PhD student Alexandra Waldenstrom used ultra-short pain-inducing heat pulses on newborn rats. She discovered that once the rats were 10 days old they began to learn to withdraw their tails from the heat stimuli. Comparing this with human babies, the rat's maturity corresponds to a foetus between weeks 10 and 30, they claim.

The authors suggest that these results show pain is learnt during a key stage in foetal development and problems during this period may cause errors to occur in the pain response system. They suggest that parents might be encouraged to touch premature babies to generate the tactile feelings from the womb that encourage the pain system to develop.

ANADIN Ultra IBUPROFEN

Hits pain more than twice as fast.

Anadin Ultra's liquid ibuprofen could hit pain more than twice as fast as normal ibuprofen tablets.

* Trade Mark

www.anadin.co.uk

urther information available from
Wyeth Consumer Healthcare,
luntercombe Lane South,
aplow, Berkshire SL6 0PH

Legal Category P

ADIN ULTRA
sentation: Liquid filled, clear green gelatin oval capsule for oral administration containing 200mg ibuprofen, with 'ANADIN' printed in white ink on the shell. Uses: For the relief of mild to moderate pain including rheumatic and scular pain, backache, neuralgia, migraine, headache, dental pain, dysmenorrhoea, feverishness, and for relief from cold and influenza symptoms. (Pharmacy Only-Also symptomatic relief of the pain of non-serious arthritic ditions). Dosage: For all indications. Adults, the elderly and children over 12 years of age, 1 or 2 capsules every 4 to 6 hours as required. The capsules should be taken with water. Do not exceed 6 capsules (1200mg) in any 24 ir period. Not to be used for children under 12 years of age. Contraindications: Use in patients hypersensitive to any of the ingredients. Use in patients hypersensitive to aspirin or with bronchospasm, asthma, rhinitis or urticaria ociated with non-steroidal anti-inflammatory drugs. Ibuprofen should not be given to patients with current or previous peptic ulceration. Interactions: Concurrent aspirin or other NSAIDs may result in an increased incidence of erse reactions and may enhance the effects of anticoagulants. NSAIDs may diminish the effect of anti-hypertensives or diuretics. Increases in serum lithium concentrations following administration of ibuprofen may be clinically ificant. Concomitant administration of ibuprofen with moderate and high doses of methotrexate may lead to serious and fatal methotrexate toxicity. Patients with reduced renal function may be at additional risk of toxicity n the combination even when low doses of methotrexate (20mg/week) are used. Precautions and special warnings: Bronchospasms may be precipitated in patients suffering from or with a previous history of bronchial asthma llergic disease. Caution is required in patients with renal, cardiac or hepatic impairment since renal function may deteriorate. The dose should be as low as possible and renal function should be monitored. Undesirable effects be minimised by using the minimum effective dose for the shortest possible duration. The elderly are at increased risk of the serious consequences of adverse reactions. Side-effects: Hypersensitivity reactions which may ist of non-specific allergic reactions and anaphylaxis. These may be experienced as: a) respiratory tract reactivity b) assorted skin disorder. Gastro-intestinal and skin disorders are most frequently reported. Adverse effects ude the following:- Gastro-intestinal: Abdominal pain, nausea and dyspepsia, constipation, diarrhoea and occasionally peptic ulcer and gastro-intestinal haemorrhage. Skin: Rashes, pruritus, urticaria, angiodema, purpura and sional exfoliative dermatitis and epidermal necrolysis. Haematological: Most frequently thrombocytopenia, but occasionally agranulocytosis and aplastic anaemia. Renal: Haematuria, interstitial nephritis, renal papillary osis and renal failure have occasionally been reported. Respiratory: bronchospasm may be precipitated in patients suffering from or with a previous history of bronchial asthma or allergic disease. Other: Rarely hepatic unction, headache, hearing disturbances and dizziness. Use in pregnancy and lactation: While no teratogenic effect has been demonstrated in animal experiments, use of Ibuprofen during pregnancy should, if possible, be ded. The onset of labour may be delayed and duration of labour increased. Ibuprofen does appear in breast milk in very low concentrations but is unlikely to affect the breast fed infant adversely. Effect on ability to drive and machines: None known. Incompatibilities: None. Overdose: In cases of overdosage, headache, vomiting, drowsiness and hypotension have been reported. Hyperkalaemia may develop. Treatment is supportive with gastric ge and correction of severe electrolyte imbalance if required. Pharmaceutical Precautions: Do not store above 25°C. Legal Category: 8 and 16 packs-GSL, 32 packs-P. Shelf Life: 2 years. Package quantities and Price RRP: Blister s of: 8 capsules RRP £1.65, 16 capsules RRP £2.80, 32 capsules RRP £4.65. Product Licence No: 0165/0142. Date of Preparation: January 2004. Product Licence Holder: Whitehall Laboratories Limited trading as Wyeth Consumer thcare, Huntercombe Lane South, Taplow, Berkshire, SL6 0PH.

Head lice

The children are back at school and pediculus capitis are looking for new scalps after the isolated summer months. Head lice may not seem like a major problem to children – they are not an excuse for staying off school – but they can be a persistent problem for parents

Head lice infestation is most common in children aged 4-12, and they are likely to have had the problem for several weeks before it is discovered. Head lice show no preference for hair type although girls are more likely to find themselves infested than boys. It is estimated that the NHS and the general public spend at least an annual £25 million on treatments.

Two approaches to treatment are currently recognised[1]:

Wet combing with fine, long toothed comb. This will remove head lice and loosen eggs (nits) from the hair shaft. The process must be undertaken meticulously to be successful, and should be repeated every four days for at least two weeks. This ensures the reproductive cycle of the louse is broken (see panel) and the likelihood of re-infection is reduced. Combing lotions like Lice Attack can help. Visit ***www.nits.net*** for more information about 'bug busting' using the wet combing method.

Recognise the problem

- Head lice are grey/brown and about 1-3mm long – the size of a sesame seed.
- The female lays eggs (smaller than a pinhead) on the hair shaft near the scalp surface (hence the need to use a long toothed comb that can get close to the scalp). The eggs are glued to the hair shaft and will not be shifted by shampooing. They are usually found above the ears and around the hair line. The eggs hatch after seven days, leaving behind empty shells (nits) The young lice take about 9-12 days to mature into adults.
- Head lice cannot jump or fly, so transmission requires close head to head contact.

Insecticide lotions/rinses Two applications of an insecticide should be used seven days apart. The second application should kill nymphs emerging from eggs that survived the first application. Since resistance to the established insecticides available over the counter (malathion, permethrin and phenothrin) is a growing problem, pharmacists should contact their local primary care organisation to find out which is the first choice product in their locality.

Which method is the most effective is the subject of some debate, and parental preference can be a strong influence. What is certain is that for either approach to be successful it must be carried out properly. Close contacts should be checked for head lice using a detection comb, and all those found to be infested should be treated at the same time.

If using an insecticide lotion or rinse it should be applied for 12 hours before being washed off. Aqueous products (as opposed to alcohol based) should be used for young children, and for people who suffer from asthma or eczema. Pregnant or breastfeeding mums should use wet combing if possible, as should children under two years of age.

Reference:

1. www.prodigy.nhs.uk/guidance

PHARMACY

PHARMACY

Life on the road for the Medicine Man team

Pharmacy in the **fast lane**

James Powell, whose Medicine Man pharmacies travel to festivals and sporting events around the country, gives an insight into the world of mobile pharmacies

By 12.30pm on July 11 this year, as Michael Schumacher donned his helmet to start his day's racing at the F1 Grand Prix at Silverstone, the staff of Medicine Man Pharmacy had already been working for seven and a half hours.

Medicine Man is the first event pharmacy company in the world, providing temporary pharmacies at some of the top sporting events in the country. Travelling from Chichester to Glasgow in a hectic five months, we cover motorsport, horse trials, golf, airshows, county shows, pop festivals and even the odd hot air balloon festival.

This year my five staff and I treated the sick among the 300,000 people who attended the British Grand Prix. By far the majority of cases we treat involve pain and hangovers, which is the reason we have 12ft of shelf space for Nurofen alone. But during the Grand Prix we also dispensed 20 prescriptions, made 10 emergency supplies (mostly Ventolin inhalers), and treated everything from verrucas to earwax. Just because people have come for a day out does not mean that there is not a demand for medicines.

I started Medicine Man Pharmacy in 1999 with my wife Claire. We had a village pharmacy in Smallfield, Surrey, and once a year 30,000 cyclists passed our front door on a Sunday morning during the London to Brighton charity cycle event. We decided to open for the ride in 1998 and took an average week's turnover in just three hours, selling out

Continued on page 48

Each category of event makes different demands on Medicine Man's resources. For example, Nurofen sales rise in relation to the noise levels at events like rock concerts

of Nurofen, sun protection and Sudocreme. Sweat rash between the legs was one condition I had not expected but, looking back, was an obvious result of cycling 55 miles in the summer. We also sold loads of plasters for grazes – mostly sustained in accidents caused by cyclists who, seeing we were open, were braking hard to stop and causing some pretty unpleasant pile-ups. I was finally contacted and asked to advertise the fact that we were an open pharmacy, with signs for two miles before the village.

The lessons learned from 17 years in community pharmacy are of no use in event pharmacy. In our first year, Medicine Man made a trading loss by not selecting events properly. Today I am far more selective, using a 10-question system where I score up to 10 points per question. I only offer the service at those events which score more than 80 points out of 100.

However, there can still be spectacular failures at some events. At the Mildenhall Airshow in 2000, we lost more than £3,500 in three days. Our costs included: £1,500 site rental, £500 accommodation, £1,000 wages, £[illegible]00 transport costs, a £120 registration fee and £[illegible]00 insurance. But it rained heavily for [illegible] so, although there were 350,000 [illegible], many stayed in their cars.

[illegible] Man Pharmacies each have separate NHSO3 registration. In fact, we have the only pharmacy in Hyde Park, London, although it trades for just one day each year at the Capital Radio Party in the Park concert.

The demands on us are unique for each category of event. At our first festival we sold 30 packs of loperamide on the first day. I quickly discovered that it is part of festival culture to take large doses of loperamide on day one to bung your digestive system so that you do not have to use the disgusting lavatories. This is now the first thing that I instruct pharmacists and new staff upon. Consequently we sell far less now.

Dyed black hair

Some incidents are a little more frightening. At a recent heavy rock festival I was sleeping in the pharmacy having completed a gruelling 12 hour day when, at 3.00am, 25 drunk Goths – dressed in black, with dyed black hair and fingernails – started banging on the Portakabin walls chanting: "We want drugs." Due to the nature of the business and the high regard in which event organisers hold Medicine Man, there were 40 security guards dealing with the incident within three minutes.

Medicine Man has been at the Grand Prix for five years. We stock 3,000 packs of Nurofen, 500 packs of Zirtek, 2,000 packs of ear plugs, but only 200 films. Sadly, photography has gone digital so sales of camera film have plummeted – but this category has been almost replaced by the huge increase in sales volume of batteries, which digital cameras seem to consume.

Looking around the shelves in the pharmacy, one could be at almost any high street medicines counter, with the exception of the Nurofen and Zirtek displays.

This is more of a lifestyle of pharmacy. It's a life of fitting and stocking on a Wednesday, then packing everything away late on a Sunday evening. And that's combined with huge potential losses – so those are probably the main reasons that Medicine Man is still the only company dedicated to this niche.

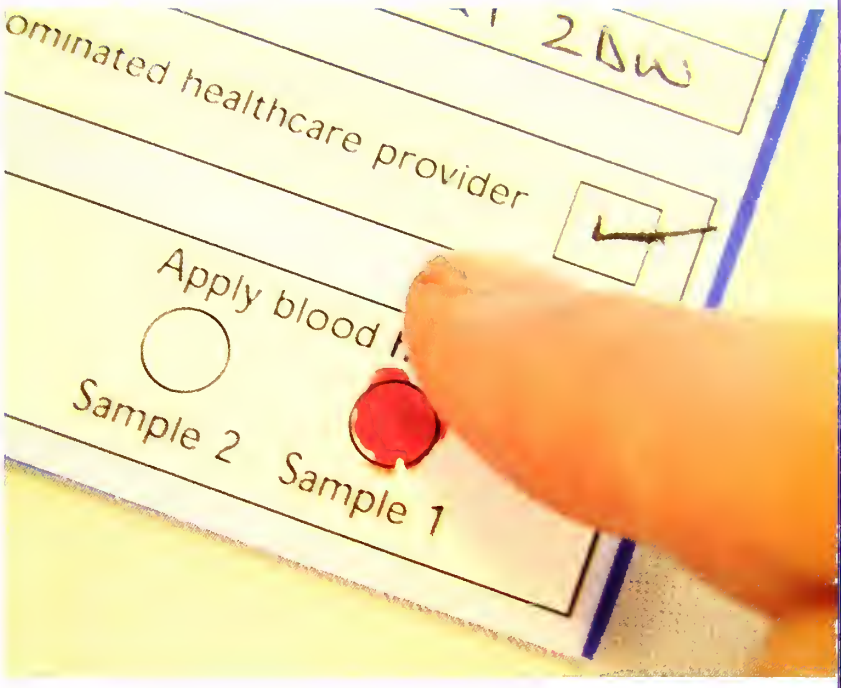
But, as pharmacists, we must stop using the walls of our pharmacies as blinkers. We must make ourselves available to the public wherever they need us if we expect them to respect us as an integral part of the healthcare team. I just choose to help them in the middle of a field or at the side of a noisy racetrack.

I wouldn't change my life for anything; I only wish that I could find events during the winter. As to how much money I make, let's say it's not enough not to have to work as a locum in the winter.

In the future Medicine Man will look to franchise its operations in various regions of the country. But don't expect to see much of the action at an event. At the Ryder Cup in 2002, the only golfer I saw was Colin Montgomery arriving at the hotel on the Monday, yet the pharmacy was only 50m from the 18th green.

Diabetes – HbA_{1c} testing

Recent guidelines issued by NICE have a strong focus on HbA_{1c} testing, here we review the test and the opportunities it offers retail pharmacies



The diagnostics market has grown dramatically over recent years and is expected to rise to more than £60m by 2007. The National Pharmaceutical Association believes "This represents a fantastic opportunity for pharmacists to extend and offer services which meet the Government's agenda for modernisation".

Currently almost 60% of British people have self-diagnostics products in their homes, the most popular being diabetes tests for urine sugar monitoring (68%) followed closely by blood glucose monitoring (53%).

Why test?

Currently most people with diabetes are asked to test their blood or urine for sugar, as studies have shown that overall good glucose control reduces the risk of diabetes complications. However many patients are not aware that a different blood test is conducted at their annual review, commonly known as Haemoglobin A_{1c} (HbA_{1c}).

Patients are asked to check their own sugar levels at home to ensure their diabetes plan is working. An HbA_{1c} blood test gives a 3 month blood glucose average, and is now considered the cornerstone of diabetes care.

If a patient generally allows their blood glucose to go up but thinks by sticking to a healthy diet, exercise and healthcare regime for a few days before clinic in the hope they will get a low A_{1c} result, it won't work.

How it works

Haemoglobin is a protein inside red blood cells. It is the part of the red blood cell that carries oxygen but also carries glucose. As glucose can stick to all kinds of protein it will stay on the red cells for the remainder of its life cycle.

As the life cycle of a red blood cell is three months, a Haemoglobin A_{1c} test carried out regularly will give the patient and their medical team an accurate guide to the average glucose, despite any last minute attempts to disguise bad control.

Opportunities

Currently patients are only offered one or two HbA_{1c} tests per year. However most patients are committed to improving their health and would like the opportunity to have more frequent HbA_{1c} tests. This combined with new NICE recommendations that HbA_{1c} tests are given up to 6 times a year, offers pharmacists an opportunity to extend their service and possibly to agree a contract with their local GPs. They could offer on-site testing or provide testing kits to patients, which would be completed at home, sent to a central laboratory for analysis and results sent directly to the patient and GP.

With this type of joined-up approach to the provision of healthcare, pharmacists will be successfully integrated into the primary care team.

Summary:

- **Pharmacists should speak to PCT's about providing diagnostic testing**
- **Patients with Diabetes should have HbA_{1c} tests up to 6 times per year**
- **HbA_{1c} tests should be done alongside home blood glucose testing in line with the patient's care plan**

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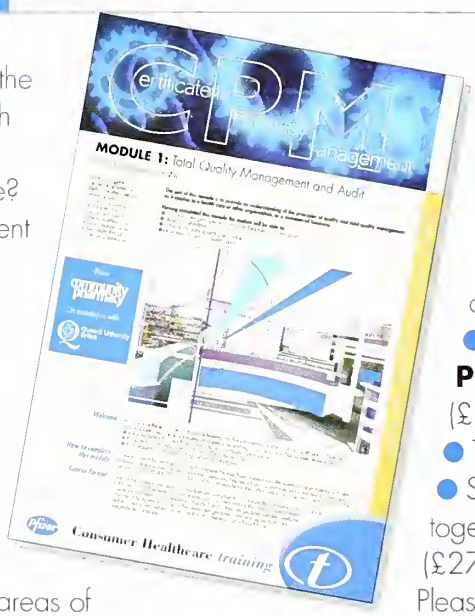

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Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@cmpinformation.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

Products and services

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Tax Consultants & Accountants

Clockwise from top left are Gaynor Langley, Joanne Campbell, Jeff Bulmer and Matthew Lakelin

Allergan has announced the appointment of **Trevor Jones** to its board of directors. A fellow of the Royal Pharmaceutical Society, Professor Jones has recently retired as director-general of the Association of the British Pharmaceutical Industry and was Wellcome's main board director from 1987-1994.

Jeff Bulmer has been promoted to AAH hospital service director with board level responsibility for the hospital sector within AAH Pharmaceuticals. Mr Bulmer will be responsible for refining supply chain quality through IT, service and partnership working and takes over from **Jeremy Poole**, who is retiring but will continue in a consultancy role at the company.

The marketing team at Menarini Diagnostics has been strengthened with the appointment of three product managers. **Yvonne Lay** will be managing the Glucomen blood glucose monitoring range, **William Murray** will hold responsibility for the GlucoDay continuous glucose monitoring system, and **Garry Alderson** has become product manager for glycated haemoglobin and urinalysis.

Penn Pharmaceutical Services has announced the appointment of **Gaynor Langley** as head of compliance. Ms Langley is a Qualified Person and has moved from Alpharma where she was the good manufacturing practice co-ordinator. In her new role, Ms Langley will be responsible for managing compliance enhancement and site validation projects, and hosting client audits.

Also new at Penn is **Joanne Campbell**, who has joined the service provider as a quality control analyst. Ms Campbell will hold overall responsibility for the testing of raw and processed clinical trials materials and packaging components prior to release. In addition, **Matthew Lakelin** has joined Penn's business development team from Ortho-Clinical Diagnostics.

Tonbridge has been placed well and truly on the map. Not only is it the home of *C&D*, but also the home town of Olympic athlete and double gold medal winner Kelly Holmes. Last week's issue was held up as we joined the throng in Tonbridge High Street. Congratulations, Kelly

Another Kelly gets a lift

There's no danger that anyone at the Wardles depot in Hanley, Staffordshire will make any comments about women drivers in the future – Kelly Barker has made sure of that. For the 23-year-old has become the company's first female forklift truck driver.

After depot manager Brian Horler recommended she go on the course after only five weeks in the warehouse, Ms Barker passed all of the programme, including health and safety and a driving test. Mr Horler said: "I am really proud of Kelly's achievements. It is unusual for women to be interested in driving forklift trucks and so it really highlights Kelly's ambition."

Wardles, the pharmaceutical wholesaling arm of United Co-operative, recently received the Investors in People award.

Over 1,000 Wyeth members of staff went 'dotty' recently to raise over £4,000 for the Meningitis Research Foundation. As well as employees paying £1 to wear an item of clothing with dots on, a raffle and 'Pimms and strawberries' party were held as part of 'Dotty Friday' on August 20. Pictured from the left are Chris Mayhew, Letitia Wright, Tracy McGee, Darryl Jackson, Danielle Clarke and Jill Ashton from Wyeth's clinical trials distribution centre in Havant who sported some of the more extreme outfits seen on the day

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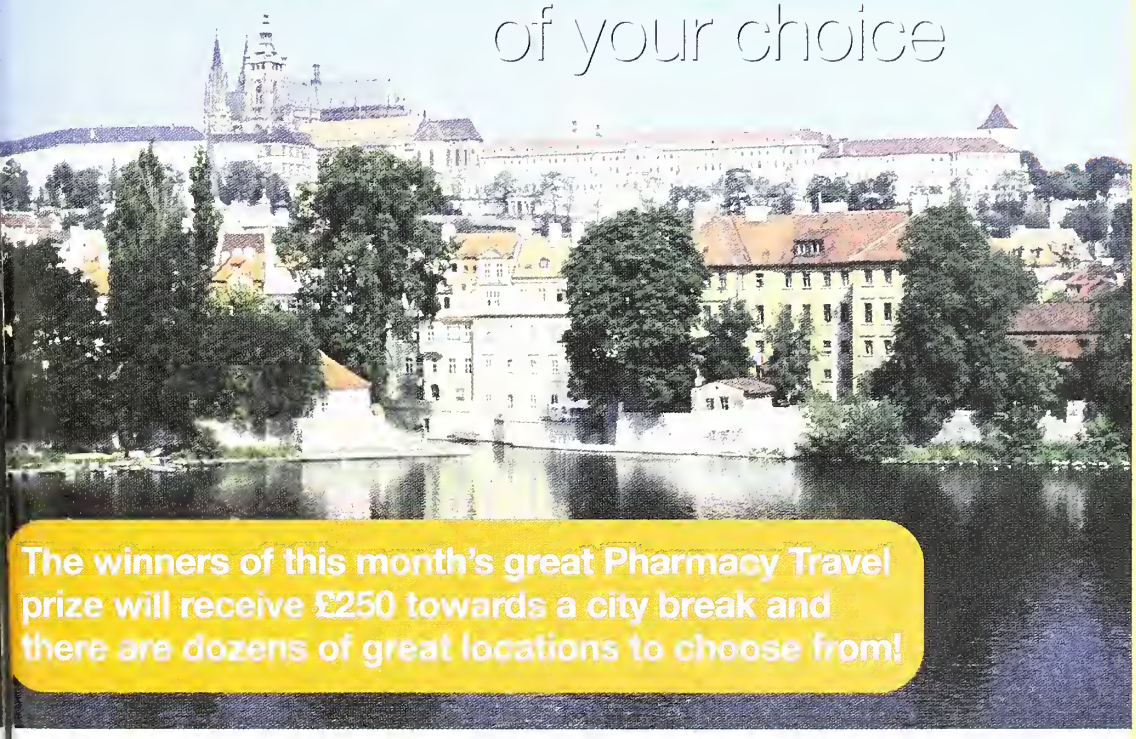

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References: 1 Hadgraft J, et al (2003) Skin Penetration of Topical Formulations of Ibuprofen 5%. An In Vitro comparative study. Skin Pharmacology and applied Skin Physiology Vol 16, No 3, pp. 137-142. **2** Whitefield M, O'Kane CJA and Anderson S (2002) Comparative efficacy of a proprietary topical ibuprofen gel and oral ibuprofen in acute soft tissue injuries: a randomized, double-blind study. Journal of Clinical Pharmacy and Therapeutics 27, 409-417. **3** source: IRI Infoscan: 52 w/e 12 June 2004 data